THE PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

STRATEGIC INFORMATION MANUAL *FOR IMPLEMENTING PARTNERS IN SOUTH AFRICA*

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Version III

INFORMATION IN THIS MANUAL IS BASED UPON OFFICIAL PEPFAR INDICATOR GUIDANCE DATED JULY 29,2005

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Acronyms and Abbreviations

AB	abstinence and be faithful
ABC	abstain, be faithful, and, as appropriate, correct and consistent use of condoms
AIDS	acquired immunodeficiency syndrome
ANC	antenatal clinic
ART	antiretroviral treatment
ARV	antiretroviral (drug)
BCC	behavior change communication
BSS	behavioral surveillance survey
CBO	community-based organization
CDC	Centres for Disease Control and Prevention (United States)
COP	Country Operational Plan
CSW	commercial sex worker
CT	counseling and testing
DHS	Demographic and Health Survey
DOD	Department of Defense (United States)
DQA	Data Quality Audit
DQP	Data Quality Plan
FBO	faith-based organization
FY	fiscal year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria; *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis, and Malaria* (see references)
HHS	Department of Health and Human Services (United States)
HIV	human immunodeficiency virus
HMIS	health management information system
IDU	injecting drug user
IEC	information, education, and communication
M&E	monitoring and evaluation
MIS	management information system(s)
MSM	men who have sex with men
NGO	non-governmental organization
OGAC	Office of the Global AIDS Coordinator (United States)
OI	opportunistic infection
OVC	orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief (PEPFAR)
PCR	polymerase chain reaction
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
RARG	WHO Injection Practices, Rapid Assessment and Response Guide
SAG	South African Government
SI	Strategic Information
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

Introduction

The purpose of this manual is to provide overall Strategic Information/Monitoring and Evaluation (SI/M&E) guidance for all United States Government (USG) partners implementing the President's Emergency Plan for AIDS Relief (PEPFAR). SI/M&E is a key component of PEPFAR in order to appropriately plan and monitor programmes and to ensure that money is spent both effectively and efficiently. Placing a greater emphasis on SI/M&E will improve programmes and aid our partners in absorbing the increased levels of funding.

Monitoring and evaluation of PEPFAR is conducted at the global, national, and project levels. It is important to understand the larger context of national and global goals and M&E guidelines in order to gain a better understanding of the rationale for specific PEPFAR data and reporting requirements. However, M&E should not be viewed only as a set of requirements but rather as a vital tool for all programme partners to use to initiate positive and effective change within their own projects. The USG SI/M&E team intends to support an increased emphasis on M&E as part of effective programme implementation.

The aim is to provide a manual that is useful for both new partners who are less familiar with the USG M&E systems and for partners with extensive USG experience who will need this information to guide them through the recent changes. The USG SI/M&E team also conducts regular workshops for partners focusing on M&E at the programme level. In addition, the USG SI/M&E team is available to answer questions and provide further M&E guidance and concrete support to foster partnership forums as we move forward.

The development of this manual is an iterative process as many of the key M&E tools are still under development or are undergoing continued refinement. The manual begins with an overview of key M&E concepts, and then continues with guidance on indicator development, an introduction to data quality, and guidance for reporting on PEPFAR indicators (July 2005 version; detailed definitions are available in the glossary), and several resources as appendices including indicator reference sheets and a glossary of M&E terms.

We welcome your comments and input on the manual as we work towards creating a document that will best suit our partners' needs.

Overview of M&E for HIV/AIDS Programmes

As the body of knowledge surrounding HIV grows, so does the interest in monitoring and evaluating the success of programmes designed to reduce the spread of infection and the impact it has on the lives of families and communities. This interest comes from national governments, programme directors, and international donors who support their efforts. The need for better M&E systems has also spawned a growing number of data collection instruments and indicators. M&E systems track what is being done and whether the programme is making a difference. M&E systems allow programme managers to calculate how to allocate resources to achieve the best overall result. However, the HIV epidemic is relatively new, consequently, new interventions are constantly proposed, and each must be shown to be effective to justify becoming part of a South African or international response. This section gives an overview of the different functions of M&E and the main features of a sound M&E system.

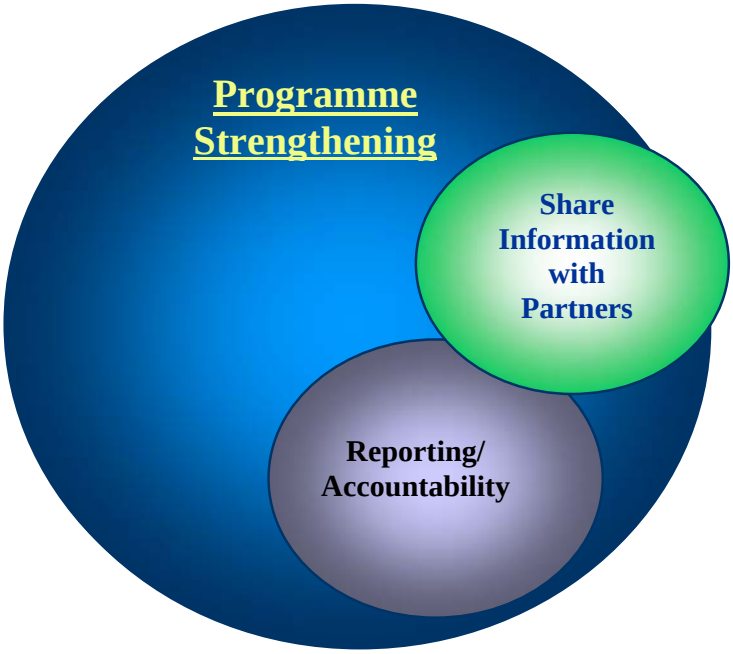
HIV is politically charged in most countries. Influential religious, political or popular lobbies may oppose intervention, and senior decision makers may be reluctant to tackle the issue in consequence, preferring to focus on maternal mortality, child nutrition or other more "politically neutral" programmes. It is in this context that M&E is perhaps most useful to all programmes. Only careful measurement and recording of the success of existing initiatives will persuade reluctant policy makers to expand programme efforts.

M&E Basics

Monitoring and evaluation helps programme implementers make informed decisions about programme operations; make the most effective and efficient use of resources; determine the extent to which the programme/project is on track; and to make any needed corrections accordingly. Finally, M&E helps programmes evaluate the extent to which the programme or project is having or has had the desired impact.

M&E is indispensable because these tools inform planners, managers, and implementers whether – or to what extent – the programme or project is operating effectively and according to expectations. By keeping track of specific areas of programme performance, operational problems can be identified while they can still be corrected and thus ongoing performance can be improved. Meanwhile, managers can also keep track of the extent to which activities are having their desired effects. Results demonstrated through good monitoring and evaluation techniques also enable decision makers to correct strategies or even overcome unanticipated difficulties. In sum, M&E improves the programme's ultimate impact through better information and increased understanding even while activities are in progress.

The diagram below illustrates that programme strengthening is the most important M&E goal. Reporting/accountability and sharing information with partners are also important, but should be accomplished without sacrificing programme strengthening.



The significance and value of M&E is realized only through the **use of M&E data**. It is not important in and of itself to collect numbers, even the best numbers, nor is it abstractly important to construct the perfect indicators. If data is not reviewed and interpreted and then fed back into decision making, the ultimate purpose of M&E -- programme improvement -- cannot be met. To be effective, it must be M&E that is actively used in problem-solving within the ongoing programme, and in further steps of the decision making process.

The Different Functions of Surveillance, Monitoring and Evaluation

While surveillance, monitoring and evaluation all have different functions, there is a great deal of overlap among the three activities. This section clarifies the different functions of surveillance, monitoring and evaluation.

Surveillance, monitoring and evaluation all play a role in providing information to help determine the links between programme efforts and resources, and to determine the programme's goals. In the case of national AIDS programmes, the ultimate goals will be to reduce the spread of HIV, to improve care for those infected, and to minimize the social and economic impact on affected families and communities. For a programme to achieve its goals, **inputs** such as money and staff time must result in **outputs** such as stocks and delivery systems for drugs and other essential commodities, new or improved services, trained staff and information materials. If these outputs are well designed and reach the populations for which they were intended, the programme is likely to have positive short-term **outcomes** or effects such as a higher age at first sex among young people. These positive short-term outcomes necessarily lead to changes in the longer-term **impact** of programmes, measured in fewer new cases of sexually transmitted infections (STIs) or HIV, or less HIV-associated deaths.

Surveillance and monitoring and evaluation activities are all needed to track whether programme inputs are producing the desired outputs, whether those outputs are having an effect and, ultimately, whether the effect is having the impact that the programme aims to achieve. But each fulfills a different function, as described below.

Surveillance is the routine tracking of disease (disease surveillance) or, less commonly, risk behavior (behavioral surveillance) using the same system over time. Surveillance helps describe an epidemic and its spread, and can contribute to predicting future trends. In the case of HIV, surveillance systems typically track impact in terms of HIV, and sometimes STI prevalence, and effects in terms of sexual risk behavior. It is typically performed at both district and national levels.

Monitoring is the routine tracking of priority information about a project or programme and its intended effects. This is likely to include monitoring of inputs and outputs through record-keeping and regular reporting systems as well as health facility observation and client surveys. Data are compiled and forwarded to the national level to be aggregated. Such monitoring is called *programme, process* or *output monitoring*.

The linked interpretation of data from multiple indicators is a key component of useful monitoring systems. Often, one indicator alone will be unconvincing. The advocacy value of an indicator is greatly strengthened if it is presented together with other data.

In tracking the status of HIV infection, the behaviors that spread the disease, and the strength of different areas of response, monitoring indicators function like the "vital signs" of the HIV epidemic at a district, regional or national level. They help programme managers determine which areas are in need of greater effort, and flag questions that might contribute to an improved response but that can only be answered by more refined research methods than those used in routine surveillance and monitoring.

Evaluation is a collection of activities designed to determine the value or worth of a specific programme, intervention or project. That means being able to link a particular output or outcome directly to a particular intervention. Three levels or phases of evaluation are distinguished. The first phase involves the assessment of the programme's content, scope or coverage, together with the quality and integrity of implementation. It is known as process evaluation. If findings from this phase are adequate, then and only then, evaluation activities are designed to determine the programme/intervention/project's immediate or short-term effects or outcomes. This phase is typically called *outcome evaluation.*

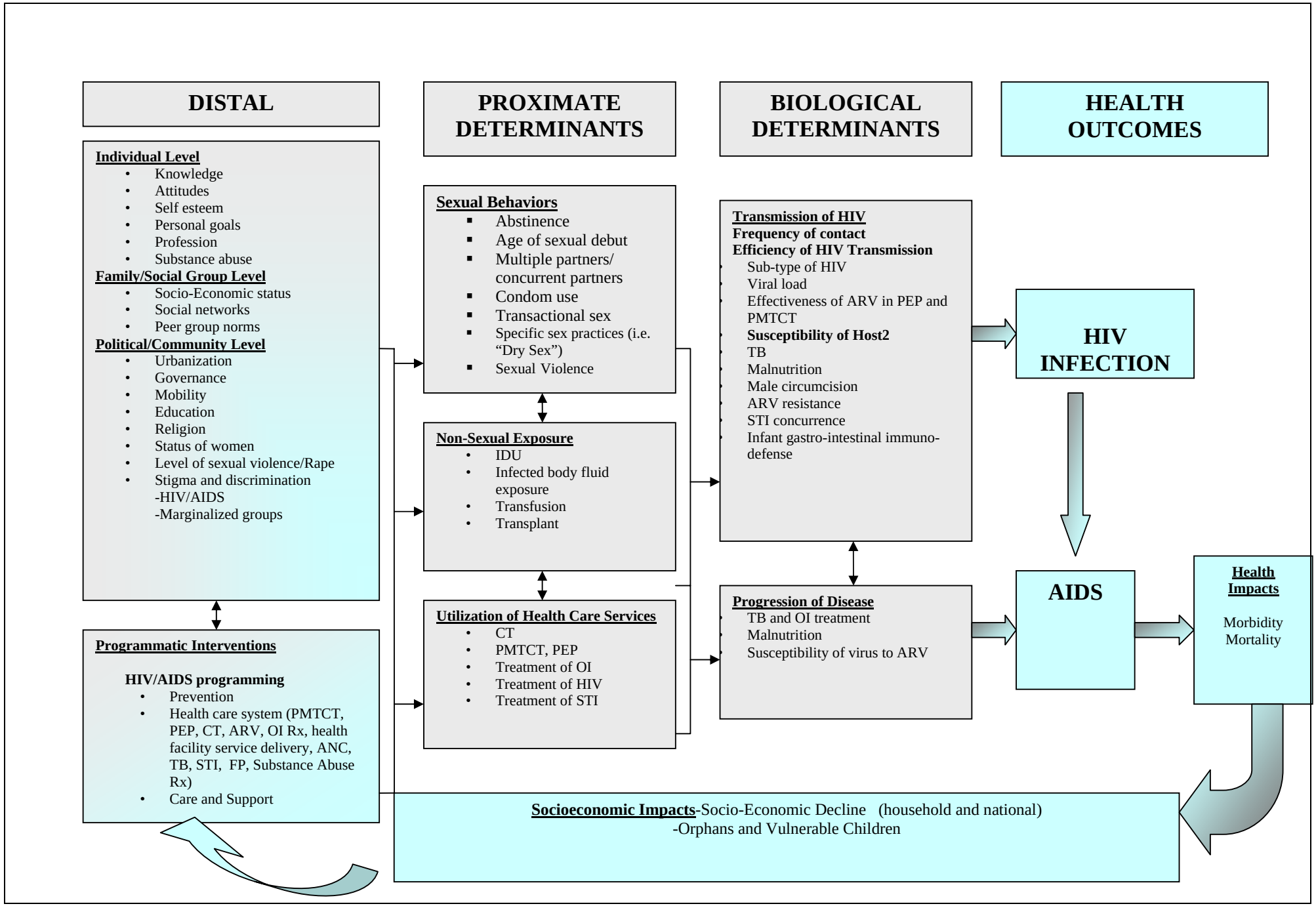
What is the difference between outcome monitoring and outcome evaluation? Essentially, *outcome monitoring* tracks changes in outcomes following the implementation of a programme or project, but is not able to attribute those changes directly to the intervention. In *outcome evaluation*, however, the intervention is designed specifically with the intention of being able to attribute the changes to the intervention itself. Without the appropriate evaluation design, the monitoring of outcome indicators alone cannot produce causal evidence about the effectiveness of a specific programme. At the very least, the evaluation design has to be able plausibly to link observed outcomes to a well-defined programme, and should be able, too, to demonstrate that changes are not the result of non-programme factors.

If there is adequate evidence that the programme/intervention/project has achieved or is achieving (if the project is ongoing) its immediate or short-term objectives, then, and only then, one goes on to determine the longer-term impact. This assessment of the longer-term effects of a programme is called *impact evaluation*. In the case of HIV, an *outcome evaluation* may aim to demonstrate that a specific project has actually reduced risk behavior, while an *impact evaluation* would aim to demonstrate that the change in behavior attributable to the project had an impact in terms of reduced transmission of HIV. Impact evaluations take a long time, are expensive, and are methodologically very complex. This is due to multiple influences that accumulate over time, and that make it difficult to pinpoint what led to any observed changes. Trying to pinpoint the exact cause of behavior change or of reduced HIV incidence often involves a rigorous study design that enables the researcher to distinguish between the effect of the intervention itself and the effect of other factors that may have influenced an outcome. Such study designs usually include a control group that has not been exposed to a particular intervention. With a fatal disease such as HIV, establishing controlled studies is often ethically problematic. In addition, most national AIDS programmes attempt to attack the epidemic on a number of different fronts simultaneously so it is difficult to determine which intervention played what part in reducing the risk of infection or improving the quality of life of an infected person. Depending on the size of the intervention, it is not always appropriate for projects/programmes to do this level of evaluation due to the factors mentioned above.

Using a Conceptual Framework to Better Understand, Monitor and Evaluate a Programme

Conceptual frameworks are diagrams that identify and illustrate the relationships among all relevant systemic, organizational, individual, or other salient factors that may influence programme/project operation and the successful achievement of programme or project goals. The framework provides a perspective for understanding programme objectives within a complete context of relevant factors in an operating environment. It also clarifies analytical assumptions and their implications for programme possibilities or limitations on success, as well as measuring and analyzing that degree of success.

The following framework presents all the different elements that can influence the success of an HIV/AIDS programme including individual, family and political/community level factors and programmatic interventions, and they all influence proximate and biological determinants and ultimately health outcomes.


DISTAL
PROXIMATE DETERMINANTS
BIOLOGICAL DETERMINANTS
HEALTH OUTCOMES
Individual Level
Knowledge
Attitudes
Self esteem
Personal goals
Profession
Substance abuse
Family/Social Group Level
Socio-Economic status
Social networks
Peer group norms
Political/Community Level
Urbanization
Governance
Mobility
Education
Religion
Status of women
Level of sexual violence/Rape
Stigma and discrimination
-HIV/AIDS
-Marginalized groups
Programmatic Interventions
HIV/AIDS programming
Prevention
Health care system (PMTCT, PEP, CT, ARV, OI Rx, health facility service delivery, ANC, TB, STI, FP, Substance Abuse Rx)
Care and Support
Sexual Behaviors
Abstinence
Age of sexual debut
Multiple partners/ concurrent partners
Condom use
Transactional sex
Specific sex practices (i.e. "Dry Sex")
Sexual Violence
Non-Sexual Exposure
IDU
Infected body fluid exposure
Transfusion
Transplant
Utilization of Health Care Services
CT
PMTCT, PEP
Treatment of OI
Treatment of HIV
Treatment of STI
Transmission of HIV
Frequency of contact
Efficiency of HIV Transmission
Sub-type of HIV
Viral load
Effectiveness of ARV in PEP and PMTCT
Susceptibility of Host2
TB
Malnutrition
Male circumcision
ARV resistance
STI concurrence
Infant gastro-intestinal immuno-defense
Progression of Disease
TB and OI treatment
Malnutrition
Susceptibility of virus to ARV
HIV INFECTION
AIDS
Health Impacts
Morbidity
Mortality
Socioeconomic Impacts-Socio-Economic Decline (household and national)
-Orphans and Vulnerable Children

A Monitoring and Evaluation System

A coherent M&E system contributes to more efficient use of data and resources by ensuring, for example, that indicators and sampling methodologies are comparable over time and by reducing duplication of effort. Where resources are scarce, this is an important asset. Data generated by a comprehensive M&E system ought to serve the needs of many constituents, including programme managers, researchers and donors, eliminating the need for each to repeat baseline surveys or evaluation studies when they might easily use existing data. Good coordination should lead to better use of resources.

From the point of view of the national programme, a coherent M&E system helps ensure that donor funded M&E efforts best contribute to national needs, rather than simply serving the reporting needs of agencies or legislatures overseas. A further advantage of coordination in monitoring and evaluation is that it encourages communication between different groups involved in the national response to HIV. Shared planning, execution, analysis, or dissemination of data can reduce overlap in programming and increase cooperation between different groups, many of whom may work more efficiently together than in isolation.

From the point of view of an NGO, a coherent M&E system helps ensure that inputs contribute to desired results. This requires that high quality information is collected and used in a consistent way.

Successful M&E systems share common elements. A list of some of these elements is given in Table 1.

Table 1: Checklist of Features of a Good M&E System

M&E UNIT	• An established M&E unit • A budget for M&E that is about 10 percent of the programme budget • A formalized (M&E) link with research institutions • A formalized (M&E) link with NGOs, government bodies and donors • Epidemiological expertise in the M&E unit or affiliated to the unit • Social science expertise in the M&E unit or affiliated to the unit • Data processing and statistical expertise in the M&E unit or affiliated to the unit • Data dissemination expertise in the M&E unit or affiliated to the unit
CLEAR GOALS	• Well-defined programme goals and targets • Regular reviews/evaluations of the progress of the implementation of the programme plans • Guidelines and guidance to districts and regions or provinces for M&E • Guidelines for linking M&E to other sectors • Coordination of an organizations own M&E with national and donor M&E needs
INDICATORS	• A set of priority indicators and additional indicators at different levels of M&E • Indicators that are comparable over time • A number of key indicators that are comparable with other countries/programmes
DATA COLLECTION & ANALYSIS	• An overall data collection and analysis plan • A plan to collect data and analyze indicators at different levels of M&E • Second generation surveillance, where behavioral data are linked to HIV/STI surveillance data
DATA DISSEMINATION	• An overall data dissemination plan • A well-disseminated informative semi-annual and annual report of the M&E unit • Annual meetings to disseminate and discuss M&E and research findings among staff, stakeholders, donors, policy makers and planners • A clearinghouse for generation and dissemination of data • A centralised database or library of all HIV/AIDS/STI related data collection and ongoing research • Coordination of national and donor M&E needs for dissemination

The Monitoring and Evaluation Unit

Human capacity is a major constraint to M&E in many programmes. While M&E units or committees do exist in many programmes, they are generally understaffed. Capacity building is vital if M&E systems are to be strengthened. Ideally an M&E unit should have access to an epidemiologist, a statistician, a social scientist and a data manager.

Clearly stated programme goals. It is not possible to monitor – much less to evaluate – progress towards goals unless the programme goals are clear. An important step in developing an M&E plan is to understand interventions and systems in place and how they are currently monitored and evaluated.

A Data Collection and Analysis Plan

Once a decision has been made about what to measure, a coherent plan must be made. This plan predicts all necessary indicators and takes into account all major data collection efforts, leading to the most efficient use of resources in data collection. The data collection plan should stipulate systems by which data from other sources will be collected, reported and analysed by the M&E system. A data collection plan will detail the frequency of data collection and who is responsible for what, how much it will cost and who will pay.

A centralised database or library of all HIV/AIDS/STI related data collection contributes immensely to the efficiency of M&E efforts. The database should list ongoing data collection efforts as well as those already completed, to avoid the duplication of studies before their results are published.

A Data Use Plan

There is no point in collecting data that cannot or will not be used. The ultimate use of the data should guide the design of a coherent M&E system, especially the selection of the most appropriate indicators. A clear plan for data use and dissemination will include outlining the end users for each indicator, and how the data will be presented to them. It may include a plan for developing a shared database of information, and for sharing data among programme elements, programme managers, board of directors, headquarters, donor agencies and others. A framework for regular dissemination of information to the public may also be included. In general, the data generated by M&E systems are used in three major ways: advocating for action; planning, revising and improving programmes; and attributing change in the epidemic to interventions undertaken.

Planning, Revising and Improving Programmes

Both monitoring systems and evaluation studies generate information that should be used to improve existing programmes and to plan more successful interventions in the future. Monitoring information can be fed into programming immediately to correct for weaknesses and improve performance. This mechanism can indicate whether an intervention is on track or on budget, or whether it is producing the desired number of trained nurses or the targeted increase in condom sales outlets. Evaluation results can be used to inform future programme design, prompting a decision to replicate an intervention in other areas, or to scrap it altogether because it is expensive and not achieving the intended results.

Indicator Development

The programme goals will dictate the areas in which progress might be expected, and therefore the areas in which it might be measured. But how can "progress" in these areas be measured? This is where the choice of indicators comes in. Which indicators should be selected? A number of guiding principles can help us choose the most appropriate set of indicators for M&E of AIDS programmes. First, we need to use a conceptual framework for M&E to select indicators and to interpret results. Second, we should consider specific qualities of the indicators, such as the link with programme goals, indicator's ability to measure change, the cost and feasibility of data collection and analysis, comparability with past indicators, and comparability between countries, or population groups.

Why Use Indicators?

Tracking changes in indicators over time will help programme managers and decision makers tell how successful the programme is in meeting its goals. Indicators are just that – they give an indication of the magnitude or direction of changes over time.

However, most indicators are not designed to explain *why* a situation has changed or has failed to change – they are designed simply to measure the change. Only smaller qualitative studies can answer the "why?" question, although answering the "why?" and inquiring about "how" change occurs are essential first steps in deciding what to do about a problem. While small explanatory studies do not necessarily form part of a regular tracking system for HIV and the behaviors that spread it, they are essential links between M&E systems and policy formulation. It is worth stressing that small explanatory studies do not yield standard indicators that are comparable across countries: by definition they are trying to explain something that is situation specific.

Operations research, in which the effects of a specific intervention are assessed, also has a contribution to make. Once small scale research studies have demonstrated that an intervention can produce the desired result under ideal research conditions, operations research puts the intervention through its paces under real world conditions, carefully monitoring inputs and outputs and evaluating the outcome.

Selection of Indicators

Good indicators for M&E of HIV/AIDS programmes need to be relevant to programmes, feasible to collect, easy to interpret and able to track changes over time. The choice of indicators will depend upon the aims of the programme.

As a first step, M&E specialists should monitor the inputs and outputs of the programme. Unless these change, any change in outcome cannot be ascribed to programme effort. Input and output indicators are often relatively easy and cheap to collect; where they register change, they indicate the need for monitoring and evaluation at the outcome or impact level.

Indicators should be chosen to measure change in key areas of programme effort. Since most HIV/AIDS programmes tailor their responses to the state of the epidemic in their country, it follows that the appropriate indicators will also differ according to the epidemic state.

Needs for Data Collection

Ideally, indicators should be measurable with existing data. Most frequently, however, special data collection efforts are needed to construct reliable indicators. In general, the costs and difficulty of data

collection increases as indicators shift from input through output and effect to impact. It should be possible to collate data for input and output indicators centrally from regular health reporting systems, whereas data for many outcome and impact indicators must be collected through surveys (or surveillance) of health facilities, or in population-based surveys. The cost and incremental benefit of more regular, or more extensive data collection must also be borne in mind. It may worthwhile to increase the sample size for sentinel surveillance so that data can be disaggregated by age, yielding important information. The trade-off may, however, be to reduce the number of sentinel sites, or to reduce the frequency of surveillance.

Types of Indicators

- Number: This is a straight count. How many. This is most commonly used as an output level indicator. Examples: the number of condoms distributed in a month or the number of women who received ARV prophylaxis in a specified time period.
- Ratio: A ratio compares two or more cohorts. X vs. Y. Examples: Education levels of boys vs. girls, or the HIV incidence in the 12-15 age category vs. the 16-21 age category.
- Percentage: A percentage compares two numbers. The numerator is looking at a subset of the total and comparing a change. X compared to Y or X/Y. A percent is one step of analysis beyond collecting straight numbers; therefore it is usually used at the outcome or impact level. Examples: The percentage of clients who returned for post-test counseling out of the total number that tested. The percentage of people who were able to pass a competency test compared to the total number who attended the training.
- Average: This is obtained by adding the sum of the data set and dividing by the number of data in the set. An average is trying to pull out what is the most common number found in the data set. An average is usually used as a measure of outcome or impact. Examples: The average CD4 counts of all ARV patients at a site within a month or the average condom distribution by a programme over a year.
- Rate: This indicator involves three pieces of data. Because it is a secondary analysis, a rate is most commonly used at the outcome or impact level, especially if one element is time. Outcome and impact level indicators are long-term or over time. Examples: The number of new infections among an uninfected population over a one year time period (incidence rate).
- Index: An index is a composite of indicators, which can be assigned values, totaled and then compared. This allows items which are not necessarily similar to be compared and is used to measure outcomes or impact level results. Examples: The UNDP Development Index. This index assigns ranks to countries' education, health, economic and other social systems. The individual ranks are added together to get one sum. The sum is then compared from one country to another, and may indicate, for instance, how Cuba ranks in comparison to the United States. Another example is the orphans and vulnerable children (OVC) index. As a child enters a programme, s/he is assigned a rank from 1 to 5 in four categories: nutritional status, education, psychosocial and health. Then, after six months of enrollment in the programme, the numbers of each category are re-assessed and added together again. One can now compare the sum after six months to the initial sum to judge progress on the scale from 0 to 20 (maximum score).

The Use of Indicators at Different Levels

This manual identifies a set of indicators and measurement methods to be used at the project level. These indicators are intended to measure a broad range of issues regarding the HIV epidemic and the country's response to that epidemic. They provide a way to track changes over time in specific prevention and care

areas. They also allow comparison of the overall implementation and effectiveness of the USG response in different countries.

However, because the indicators cover so many programme areas and because substantial resources can go into collecting indicators, the number of indicators in any particular area must remain limited. This means that the set presented here will not comprehensively address all the specific monitoring and evaluation needs of individual projects to prevent and mitigate the impacts of HIV/AIDS. In this section we will briefly discuss the roles which these indicators play in M&E at three levels: international, national, and project.

International Level

At the international level, the collection of these indicators in different countries will help international agencies and donors to:

- Track the trends in the epidemic and the response on a global scale.
- Identify regional trends or patterns in the epidemic and the response.
- Highlight persistent global and regional problems in responding to the epidemic.
- Advocate for expanded resources to address the pandemic.
- Allocate financial and technical resources so as to have the greatest impact on the global pandemic.

It is therefore important that these indicators are defined and measured in the same way, across countries and regions, so that they are understandable when viewing and comparing at the global level. This manual provides detailed recommendations as to how to measure each of the indicators. Although contextual information is needed to form a full picture behind any particular indicator, taken roughly they can be compared directly from country to country.

National Level

At the national level the indicators presented in this manual can be used to track trends, identify problem areas, advocate for and allocate resources. At the national level the indicators will also inevitably contribute to evaluation of the effectiveness of the country's overall response, that is the sum total of all activities going on in-country which relate to the HIV/AIDS epidemic. In deciding on a national set of indicators, it is important that countries realize they are not limited to the set of indicators proposed by international agencies such as UNAIDS. The choice of indicators should be driven instead by the objectives, goals, and activities that constitute the national response to HIV and by the local epidemiology and epistemology of HIV and risk behaviors, keeping in mind that it costs time and money to collect and analyze data for each indicator. When necessary, however, projects should add indicators to make certain the data collected is linked to improving programmes.

Project Level

The indicators presented in this manual will not cover the full range of project monitoring and evaluation needs. Good project monitoring and evaluation requires a mix of input, process, output, outcome and impact indicators that are directly tied to the project activities, goals and objectives. These should then feed directly back into the project to improve the implementation of activities and maximize the project's impacts.

While much of the impetus for standardizing indicators has come from international bodies wishing to make cross-country comparisons, the value of standardized indicators within a country cannot be overemphasized. The M&E specialist should always bear in mind the national standard for indicators in that field when

designing monitoring and evaluating activities for a specific project. The project may have unique information needs that conform to a rigorous evaluation design. However one is often able to choose indicators with standard reference periods that allow the collected data to be fed easily into the national M&E system.

Using comparable measures can provide the national programme with valuable measures of the same indicator in different populations, permitting triangulation of findings and allowing regional or local inconsistencies and differences to be noted and addressed. This can help to direct resources to regions or sub-populations with greater needs, identify areas for intensification or reduction of effort at the national level, and aid in improving the overall effectiveness of the national response.

An Introduction to the Management of Data Quality

All projects and programmes that involve the collection, collation, manipulation and reporting of data must ensure that such data meets minimum criteria for data quality. These criteria are far more than a statistical exercise and involve the design, implementation and management of a Data Quality Management System (DQMS) documented in the Data Quality Plan (DQP). This means that persons managing the data must know and understand data quality criteria, be able to design a plan to manage data quality and be able to internally audit the quality of the data. In essence, the end user or recipient of data has a right to information that is valid, reliable and accurate. The data quality manager has the obligation to ensure that this is the case in practice. In this set of introductory notes, the reader is introduced to the:

- Minimum data quality criteria;
- Construction of a Data Quality Plan; and
- Data Quality Audit Process

As these notes are only a very brief introduction, they cannot contain comprehensive information about data quality. Nor do they guarantee that having read them, an implementing partner will be able to produce data of the highest quality. Readers are encouraged to interact with their data quality auditors and reporting partners in order to improve their data quality practices. A list of references for further information is supplied at the end.

The Criteria for Data Quality

There are five basic criteria for the establishment of data quality. These criteria originate from various statistical methods and techniques but have evolved to be equally applicable to both quantitative and qualitative data. In essence all data whether at source or post manipulation must demonstrate acceptable levels of:

- Validity;
- Reliability;
- Timeliness;
- Precision; and
- Integrity.

Measure of Validity

Validity, in terms of data quality, is the assurance that we have actually measured what we intended to measure at the outset. Thus the data is reflective of the true differences among the respondents from the population group that was evaluated. The greatest data quality risk to validity exists in the design and construction of the indicators and their associated definitions at programme level. Often an inappropriate definition is applied to an indicator, therefore attribution cannot be demonstrated. At project implementation level risks to validity occur when an implementing partner *fails* to:

- Contextualize the definition of the indicator to their own project. For example, what does training mean in your organization;
- Recognize the data that must be included and/or excluded from a data set. In terms of the PEPFAR indicators, OVC *excludes* all individuals over 18 years of age;
- Recognize whether data is directly valid or a proxy measure (see Definitions in Appendix)

- Establish the inherent biases that exist in terms of the operational definitions – is there an underlying assumption that a behavior change intervention actually leads to the intended change? This needs to be proven, not an assumption.

Measure of Reliability

In the broadest sense reliability is associated with the concepts of accuracy, precision and consistency. For the purposes of data quality, reliability is the ability of the implementing partner to be able to consistently collect data of the same quality over time. Reliability is a pre-requisite for validity. The greatest quality risks to achieving reliability occur when an implementing partner *fails to identify* those elements in the:

- Collection methodology that cannot be consistently applied. For example, a survey could be done of participants when they finish a training, with the intention of a follow-up survey being completed in six months. If the project is working with a mobile population, survey methodology will not be able to be repeated with the same group as it would be difficult to locate them again;
- Collection instruments or tools that allow for variation with time, place or persona. Any collection tool or instrument must have well documented instructions and definitions;
- Sampling frameworks which are affected by time, place or persona;
- Selection and appointment of new data management personnel which allow for the introduction of personal interpretations and data management methods;
- Arithmetic methodologies that may include rounding up or down, as well as any other form of inconsistency or data 'torture'.

Measure of Timeliness

The whole point of having quality data is to ensure that decisions regarding programmes and projects can be made in a timely manner. If significant time lags exist between the collection, collation and eventual reporting of data then the relevance of the data to the decision making process is lost. This is not to say that all data must be reported at the time it is collected and collated. Sometimes data is collected retrospectively and only reported years after its initial derivation. The quality test for timeliness is whether the data being collected, collated and reported still carries the desired relevance at the time of reporting. Timeliness as a measure of quality is negatively affected when an implementing partner *fails* to:

- Establish collection dates related to the relevance of the actions that will be taken following the reporting of the data; and
- Establish the ratio for acceptable time lags between data collection, collation and reporting. It may take a facility one month to compile service statistics. This must be built into reporting expectations that data is always one month behind actual service delivery.

Measure of Precision

Although accuracy and precision are statistically addressed with reliability, they are of such importance to the management of data quality to be measured and monitored separately. Like reliability, therefore, precision is a pre-requisite for validity. Due to the contractual nature and funding implications associated with the data reported for many programmes and projects, it is essential that there be some form of guarantee that the data is as free from bias (accuracy) and error (precision) as possible. The typical data management issues that, when *not addressed* result in data quality failure in terms of the measure of precision include identifying whether:

- There are any source errors or bias;
- The instruments used for collection, collation, manipulation and storage produce error or bias. For example, an Excel spreadsheet has been corrupted and the formula no longer is accurate;
- The sampling results in bias based on time, place or persona or in under or over reporting errors. Sampling should be random. A project could not take HIV test results from individuals who showed up to a mobile clinic on a Wednesday and extrapolate prevalence rate for that area, for example. The fact that it is a Wednesday is a time bias because many people work on a Wednesday. Also, the individuals that showed up at the mobile clinic were self-selecting and may have come to get tested because they knew they were at risk;
- The transcription methods allow for the introduction of under or over entry errors and the nature of their origin e.g. the data capturer entered 71 instead of 17;
- Calculations and other forms of data manipulation can be affected by bias and if so what form of over or under report they create. A project manager may assume that 20 percent of all patients are HIV positive, if actual results are unavailable. This may bias the data set. Ensure assumptions are backed up by data.; and
- Ensure that the margin of error is evaluated and calculate for any data set.

Often, depending on the type of data being managed, it is not possible to establish with a high degree of precision the actual degree of error. In these cases it is essential that the data quality manager is able to give an indication of the risk magnitude (high or low) and direction of the error (under report or over report). The risk magnitude is based on whether or not the expected error will be greater than the desired target the programme or project is aiming to achieve. In the case of low risk magnitudes that data can still be used for reporting purposes. The direction of the error must be established as being either a potential under report or a potential over report. It is no good establishing after the fact, during a DQA, what the margins of error are, as this is somewhat like placing an airplane on a commercial flight, full of passengers, before having tested the wing tolerances for maximum load. In essence, precision is not something that just happens, it is something that is carefully planned, measured and monitored and often acts as an early warning signal for deteriorating data quality.

Measure of Integrity

Although we would always like to believe the best of everyone the reality is that even data management systems are open to manipulation with a subsequent lack of data integrity. Sometimes the loss of data integrity, or truthfulness of the data, occurs from human error or actual human interference. On other occasions, loss of data integrity occurs when technology fails us. From a data quality perspective it is essential to know what risks exist to the integrity of the data, where in the data management process these risks exist, and to ensure that we have contingency plans to manage such risks. Classic integrity risks exist when we *fail* to:

- Establish whether the costs associated with collection lead to temptation to fudge data. For example, if an interviewer for a survey is paid for each survey that is filled out – that may lead to an interviewer to fill out additional surveys falsely;
- Establish whether there is any reason for respondents to give false data for personal or political reasons;
- Establish whether the data collectors are influenced to provide false data or manipulate the data collected;

- Establish whether the data cleaning, handling and storage systems are tamper-proof, regardless of whether the systems are electronic or hard copy based. A programme may want to limit the number of people who have access to the data set; and
- Include internal and external audit as a means of verifying and validating the DQMS.

Determining the Cost of Indicator Collection

A recommended method to use for this is a partial cost accounting basis that determines the directly attributable costs. The purpose of the exercise would be to establish a cost-benefit ratio which the organization receiving the funding could then use to determine whether or not there is benefit to be gained in improving the quality of data or not.

Method:

1. Determine the direct costs for staff involved (level of effort cost) in the data management system on a unit cost basis, regardless of whether they source, collect, collate, analyze or report the data. The unit cost is a function of the staff member's total cost to organization per month divided by their normal number of hours worked per month. This gives their unit cost per hour. The direct costs are calculated by determining the amount of time they spend, or should spend, on data management activities for a specific indicator. It is thus essential that accurate time sheets be kept in this regard.
2. Other direct costs per indicator are calculated by firstly understanding the nature of the data management system and establishing which elements in the system have a directly attributable cost. For example, a particular indicator may have printed tools for data collection. The unit cost for printing these tools would be established by knowing the number of copies made and the cost per copy plus the cost of the paper.
3. By calculating the total direct costs for an indicator an organization can determine whether an increased direct cost would be warranted to improve data quality. For example, if precision errors were running at 20% and it would take a 35% increase in level of effort costs to improve the error to 10% (i.e. an improvement of only 10%), it would be considered as an unwarranted cost and thus the data would be reported as is with a note related to the error, so that the Funder can adjust if need be. Ideally the increased costs in improving data quality should be less than the improvement being achieved.

To prevent over-complicating the calculation of the costs of an indicator, the indirect costs related to overhead and non-attributable activities are left out. Although this is not ideal in a cost accounting system, for the purposes of the cost-benefit exercise it would not be inappropriate, as the direct costs would be sufficient for proving or disproving warranted expense.

The Data Quality Plan

In order to ensure data quality and to avoid unnecessary and costly data repairs a Data Quality Plan (DQP) is developed in support of the Monitoring and Evaluation Plan (MEP) and in line with the Indicator Information Sheets (IIS). The DQP forms the basis for ensuring that the five critical elements of data quality, namely: validity, reliability, timeliness, precision and integrity, are considered during the planning for monitoring and evaluation and activity rollout. The DQP is an essential record of how the project managed its data quality issues, and is an excellent source of information for the Auditor during a Data Quality Audit (DQA).

The DQP includes explanations of how data quality will be achieved as well as the sources of information or evidence that are used to validate and verify data quality. A good DQP should also include a data quality risk analysis. An example of a generic template used for a DQP is given in Appendix D.

Establishing Risks to Data Quality

Sometimes it is not possible for data to meet all five data quality characteristics to the same degree. It is for this reason that the various aspects of data management should be evaluated for relative risk against an established and consistent risk matrix. The use of the matrix enables the data quality manager to establish those data management areas that require greater attention, contingency plans and more regular review. All data has an associated quality risk and sometimes the cost of managing the risk outweighs the additional benefit to be gained from improving the data quality. The use of a risk matrix enables the implementing partner to establish those elements within the data management system, which pose the greatest data quality risk so that the appropriate controls can be put in place to minimize the impact of a risk.

Table 1: Data Quality Risk Matrix

Overall Effect on Data Quality	Probability of Error Occurring			
	(4) - Constantly	*(3) – Frequently*	*(2) - Occasionally*	*(1) – Unlikely*
(4) - Catastrophic	**16**	**12**	**8**	**4**
(3) – Critical	**12**	**9**	**6**	**3**
(2) - Marginal	**8**	***6***	**4**	**2**
(1) - Negligible	**4**	**3**	**2**	**1**

Table 2: Data Quality Risk Analysis Table

Risk Score	Risk Type	Remedial Action
9 - 16	**High Risk**	Establish contingency plan to reduce risk, verify and validate *prior to each reporting episode*, maintain strict audit trail.
4 - 8	**Medium Risk**	Establish contingency plan to reduce risk, verify and validate *prior to annual return*, maintain strict audit trail.
1 - 3	**Low Risk**	No immediate action required; risk could be managed through normal internal audit processes.

Data Quality Auditing

Data Quality Auditing (DQA) is an established tool within the M&E field. Unfortunately it is often applied in the absence of DQPs thus yielding poor audit results. It is an excellent tool for implementers to establish and verify the quality of both their data management practices as well as the data itself. DQAs usually involve the following elements:

- A self-evaluation for keeping an internal audit record, or for submission to the external auditor for evaluation (Self-evaluation given in Appendix D);
- An on-site review of data management practices and a sampling based audit of actual data;
- Construction of compliance plans for those elements which do not meet data quality standards (both internal and external audits); and
- An audit report to the organization (internal audit) or the reporting authority (external audit).

The USG South Africa HIV/AIDS task force conducts regular DQAs of PEPFAR partners to both build capacity among partners to improve data management systems and to validate the data that are reported. The recommendations for partners and USG from the FY 05 DQAs are provided in Appendix E.

References for Data Quality

The DQA should be based on USAID Automated Directive Systems (ADS) data quality standards, specifically:

- ADS Chapter 203 Requirements for Data Quality Assessment: [http://www.usaid.gov/policy/ads/200/203.pdf]
- ADS Chapter 578 Information Quality Guidelines [http://www.usaid.gov/policy/ads/500/578.pdf]

The following documents also establish a point of reference for carrying out the DQA:

- TIPS: Guidelines for Indicator and Data Quality [http://pdf.dec.org/pdf_docs/PNACA927.pdf]
- U.S General Accounting Office, The Results Act: An Evaluators Guide to Assessing Agency Performance Plans [http://www.gao.gov/special.pubs/gg10120.pdf]
- U.S General Accounting Office, Performance Plans: Selected Approaches for Verification and Validation of Agency Performance Information [http://www.gao.gov/archive/1999/gg99139.pdf]
- U.S General Accounting Office, Standards for Internal Control in the Federal Government [http://www.gao.gov/special.pubs/ai00021p.pdf]
- Price Waterhouse Coopers (PWC): The Performance Management Toolkit -- A Guide to Developing and Implementing Performance Plans (non proprietary). This toolkit will be provided by USAID.

Reporting on Programme Results for the President's Emergency Plan for AIDS Relief

PEPFAR partners that receive funding for direct ARV treatment services are required to report on programme results each quarter by ARV service outlet. For partners working in all other programme areas, only semi-annual and annual reports are required. The reporting schedule is as follows:

- **Quarter 1 Treatment Report** (covering October 1-December 31) to be submitted end of January
- **Quarter 2 Treatment Report** (covering January 1-March 31) and **Semi-annual Report** (covering October 1 – March 31) to be submitted end of April
- **Quarter 3 Treatment Report** (covering April 1 – June 30) to be submitted end of July
- **Quarter 4 Treatment Report** (covering July 1 – September 30) and **Annual Report** (covering October 1 – September 30) to be submitted end of October

In addition, each USG agency may have additional reporting requirements. Partners should contact their USG activity manager to find out about any other requirements.

Each year, around August, partners are required to submit a Country Operational Plan (COP) that describes current and planned activities including targets for required indicators. The targets that are set in the COP are for the subsequent fiscal year and are used to monitor partner performance in the semi-annual and annual reports. The reports mentioned above include: 1) programme indicator results, including narrative sections to explain training activities, progress on targets outlined in the COP, and an explanation of direct and indirect support; 2) narrative sections explaining challenges and accomplishments; and 3) success stories.

When reporting on PEPFAR indicators, double counting should be avoided, particularly within one service/programme area and reporting period. For example, if an individual receives psychological care and treatment for opportunistic infections as part of a package of palliative care services during the same reporting period, this person should only be counted once as an individual being supported with palliative care within the reporting period. In other words, this indicator intends to capture the *number of individuals* receiving palliative care services, rather than the *number of visits* regardless if the visits are for the same or difference services that would be categorized as palliative care. However, for individuals served by multiple programme areas, it is acceptable to count individuals once for each programme area (e.g., OVC, ART, and palliative care). Persons receiving services in one reporting cycle can be counted again in the next cycle if they are still receiving services. Thus, the report shows the total number of persons currently being served within each reporting period (6 or 12 months or 3 months for treatment reports). The same applies to counting numbers of individuals trained. A person trained in a particular area or for a particular program more than once in one reporting period is only counted as one person trained. However, if this person is trained in a different programme area then s/he can be counted once for each programme area in which s/he is trained. For example, if a person is trained in providing psychosocial support for HIV-infected persons and also in the provision of opportunistic infections, s/he should only be counted once under the indicator "Number of persons trained in HIV-related palliative care." However, if a person was trained in the provision of ART and the provision of prophylaxis for opportunist infections, s/he can be counted under both indicators "Number of persons trained in the provision of ART" and "Number of persons trained in the provision of HIV-related palliative care." Lastly, if two or more PEPFAR partners are working in the same facility and/or reaching the same people, it is <u>important</u> to inform the USG agency in the narrative section of the report in order to minimize the double counting in the overall South Africa PEPFAR programme progress report. Each partner still reports their reach and progress toward their targets, however, when aggregated to a total USG sum, the USG SI team must adjust for duplicate counting.

Partners must report on all indicators that are relevant to PEPFAR-funded programme activities during the reporting period regardless of whether targets were set at the beginning of the period. For example, a treatment programme may do counseling and testing in order to enroll patients on ARVs. The number of

people counseled and tested should be reported even though a target may not have been set in the COP. If an indicator is relevant but data are not available, partners should indicate that in the report.

The indicators presented here are the minimum programme-level reporting requirements under PEPFAR. However, they represent only a subset of the information needed by programmes to effectively monitor, manage and improve their programmes locally. A good example of additional information that would be recommended is geographical coverage of service sites. Age of clients served is another useful variable that is not required in the aggregate counts (with the exception of ART), but is recommended for programme management and planning purposes. If partners would like to report on additional indicators that they are using to manage their program and measure program success, they can report those data in the narrative text sections of the quarterly, semi-annual, and annual reports.

PEPFAR partners are required to report via the Data Warehouse that is a password-protected web-based reporting system (www.sharing.org.za). To obtain further information about the Data Warehouse, please contact a USG Strategic Information Advisor.

Direct and Indirect Results

All PEPFAR indicators aim to reflect direct programme support. However, as directed by the Office of the Global AIDS Coordinator (OGAC), there are seven indicators that are collected for both "direct" and "indirect" support:

PMTCT:

- Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results
- Number of pregnant women receiving a complete course of antiretroviral prophylaxis in a PMTCT setting.

Care:

- Total number of individuals provided with general HIV-related palliative care (including TB/HIV)
- Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of all served with palliative care)
- Number of OVC served by an OVC programme.

Counseling and Testing:

- Number of individuals who received counseling and testing, and received results.

Treatment:

- Number of individuals receiving antiretroviral therapy at the end of the reporting period.

An intervention is considered to be a type of "direct" support if it can be associated with counts of uniquely identified individuals receiving care or support (or prevention messages) at a specific service delivery point that is receiving assistance from the partner. Results that are direct are documented and auditable.

"Indirect" support is an *estimate* of individuals receiving care, treatment or other services as a result of the USG's contribution to local, provincial or national activities such as policy development, logistics, protocol/guideline development and dissemination, and laboratory support.

There are three guiding principles to apply when distinguishing between "direct" and "indirect" support:

- **Frequency of assistance:** To justify a partner counting patients (or number of people served) directly, the implementing partner must be at the service delivery site at least twice monthly and the partner intervention must lead to improved availability or quality of service.
- **Results test:** In order to count an intervention as direct, the implementing partner must be able to justify that either: 1) the intervention or service would not have happened without the involvement of the organization or 2) the organization's provision of resources, staff or mentoring enabled the service/activity to take place or enhance the availability or quality of the service.
- **Auditability:** When deciding whether a partner's data should be counted as direct, the USG considers whether the numbers would withstand an external audit review. A critical determination is whether the partner has access to official records kept by the service delivery site. If the partner has access to the official patient records to support their reported results, then the figures can be included in the count of direct support.

Data Quality

PEPFAR partners are expected to report on valid and reliable data to the extent that is possible and feasible. A reasonable margin of error not greater than 10% is acceptable in cases whereby the cost of data collection and reporting exceeds the value of the data itself. Any issues around data quality must be reported to the USG agency. In addition, if estimates were used to report on the number of individuals reached, where exact counts could not be determined, the method of calculation must be reported and approved by the USG agency. Lastly, if there is more than one PEPFAR partner reporting on the same individuals reached, please indicate that in all progress reports and to the USG agency to reduce double-counting when figures are aggregated at the USG level.

South African Government Reporting

All USG partners receiving funding through PEPFAR, working in either private or public service delivery sites, are also encouraged to report data to local, provincial and national government counterparts. This data is valuable information for planning purposes and to capture program coverage and service uptake. Please contact the local or provincial government to obtain required indicators specific to a location.

Indicators for Monitoring the President's Emergency Plan for AIDS Relief

PREVENTION
Abstinence and Being Faithful
1.1 Number of individuals reached through community outreach that promotes HIV prevention through abstinence and/or being faithful (disaggregated by gender)
1.1A Number of individuals reached through community outreach that promotes HIV prevention through abstinence (disaggregated by gender) (subset of 1.1)
1.2 Number of individuals trained to promote HIV prevention programmes through abstinence and/or being faithful
1.3 Number of hours of technical assistance provided for abstinence and/or being faithful programmes to: 1) National Government; 2) Local or Provincial Government; and 3) Other NGOs
Condoms and Other Prevention
2.1 Number of targeted condom service outlets
2.2 Number of individuals reached through community outreach that promotes HIV prevention through other behavior change beyond abstinence and/or being faithful (disaggregated by gender)
2.3 Number of individuals trained to promote HIV prevention through other behavior change beyond abstinence and/or being faithful
2.4 Number of hours of technical assistance provided for condoms other prevention programmes to: 1) National Government; 2) Local or Provincial Government; and 3) Other NGOs
Medical Transmission/Blood Safety and Injection Safety
3.1 Number of service outlets carrying out blood safety activities
3.2 Number of individuals trained in blood safety
3.3 Number of individuals trained in medical injection safety
3.4 Number of facilities with good waste management and procurement systems to support injection safety
3.5 Number of public health facilities (clinics and hospitals) receiving IEC printed material on injection safety and infection control
Prevention of Mother-to-Child Transmission
4.1 Number of service outlets providing the minimum package of PMTCT services according to South African or international standards
4.2 Number of pregnant women that attended first antenatal care visit
4.3 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results
4.4 Number of pregnant women provided with a complete course of ARV prophylaxis
4.5 Number of infants receiving an ARV prophylaxis
4.6 Number of infants tested by PCR at 6-14 weeks
4.7 Number of infants tested at 12 months
4.8 Number of HIV-infected pregnant women referred to: 1) a wellness programme and 2) a treatment programme
4.9 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results (indirect)
4.10 Number of pregnant women provided with a complete course of ARV prophylaxis in a PMTCT setting (indirect)
4.11 Number of health workers trained in the provision of PMTCT services according to South African or international standards
4.12 Number of hours of technical assistance provided for PMTCT programmes to: 1) National Government; 2) Local or Provincial Government; and 3) Other NGOs
COUNSELING AND TESTING
5.1 Number of service outlets providing counseling and testing according to South African or international standards
5.2 Number of individuals who received pre-test counseling (disaggregated by gender)
5.3 Number of individuals who received counseling and testing and received their test results (disaggregated by gender)
5.4 Number of individuals who received counseling and testing and received their test results (indirect)
5.5 Number of HIV-infected individuals who were referred to: 1) wellness programme; 2) treatment programme; 3) STI services; and 4) TB services
5.6 Number of individuals trained in counseling and testing according to South African or international standards

5.7 Number of hours of technical assistance provided on counseling and testing to: 1) National Government; 2) Local or Provincial Government; and 3) Other NGOs
CARE
Orphans and Vulnerable Children
6.1 Number of OVC served by an OVC programme (disaggregated by gender)
6.1A Number of OVC receiving increased access to health care (subset of 6.1)
6.1B Number of OVC receiving antiretroviral treatment (subset of 6.1)
6.1C Number of OVC receiving support to increase access to education (subset of 6.1)
6.1D Number of OVC receiving access to economic support (subset of 6.1)
6.1E Number of OVC receiving food or nutritional support (subset of 6.1)
6.1F Number of OVC receiving legal assistance (subset of 6.1)
6.1G Number of OVC provided with or referred to psychosocial support (subset of 6.1)
6.1H Number of OVC provided with protection from abuse (subset of 6.1)
6.1I Number of OVC benefiting from community mobilisation to respond to OVC needs (subset of 6.1)
6.2 Number of OVC served by OVC programmes (indirect)
6.3 Number of family members of OVC provided with HIV-related palliative care
6.4 Number of providers/caretakers trained in caring for OVC
Palliative Care: Basic Health Care and Support and TB/HIV care
7.1 Number of service outlets providing HIV-related palliative care (including TB)
7.1.A Number of service outlets providing treatment for TB to HIV-infected individuals in a palliative care setting (subset of palliative care outlets)
7.2 Number of individuals provided with HIV-related palliative care (including TB) (disaggregated by gender)
7.2.A Number of HIV-infected individuals that received treatment for TB disease (disaggregated by gender) (subset of 7.2)
7.2.B Number of individuals that received post exposure prophylaxis (subset of 7.2)
7.2C Number of HIV-infected individuals that received cotrimoxazole prophylaxis (subset of 7.2)
7.3 Number of TB patients counseled and HIV tested and received test results (disaggregated by gender)
7.4 Number of family members of HIV-infected individuals provided with HIV-related palliative care
7.4 Number of TB cases
7.5 Number of Pulmonary TB
7.6 Number of new smear positives
7.7 Number of successfully treated TB
7.8 Number of HIV-infected individuals in a palliative care program that were referred for ART
7. 9 Number of individuals provided with HIV-related palliative care(including TB) (indirect)
7.9A Number of HIV-infected individuals who received treatment for TB disease (subset of 7.9)(indirect)
7.10 Number of individuals trained to provide HIV-related palliative care (including TB/HIV)
7.10A Number of individuals trained to provide treatment for TB to HIV-infected individuals (subset of 7.10)
7.11Number of hours technical assistance provided in HIV-related health care and support
7.12Number of hours technical assistance provided for strengthening TB/HIV services
TREATMENT
Direct ART Services
8.1A Number of service outlets providing HIV counseling and testing
8.1B Number of service outlets providing HIV-related palliative care (including TB)
8.1C Number of service outlets providing treatment for TB (subset of palliative care outlets)
8.1D Number of service outlets providing antiretroviral treatment
8.2 Number of individuals counseled and HIV tested and received test results (disaggregated by gender)
8.2 A Number of TB patients counseled and tested and received test results (subset of above)
8.3 Number of HIV-infected individuals who received pre-treatment training
8.4 Number of HIV-infected individuals who received ARV adherence counselling
8.5 Cumulative number enrolled in HIV care by the beginning of quarter (disaggregated by age, gender and pregnancy status)
8.6 New enrollees in HIV care during the quarter (disaggregated by age, gender)
8.7 Cumulative number enrolled in HIV care by the end of the quarter (disaggregated by age, gender)
8.8 Number who received HIV care during the reporting period (disaggregated by age, gender)
8.9 Number in HIV care during the quarter & eligible for art, but not started ART by the end of the quarter
8.10 Number in HIV care that are receiving treatment for TB disease (disaggregated by gender)
8.11 Number of HIV-infected individuals receiving cotrimoxazole prophylaxis

8.12 Cumulative number started on ART by the beginning of the quarter (disaggregated by age, gender and pregnancy status)
8.13 Number new on ART during the quarter (disaggregated by age, gender and pregnancy status)
8.14 Number on ART who transferred in during the quarter (disaggregated by age, gender and pregnancy status)
8.15 Number started on ART programme during the quarter (includes new and transfers) (disaggregated by age, gender and pregnancy status)
8.16 Cumulative number started on ART by the end of the quarter (disaggregated by age, gender and pregnancy status)
8.17 Number on ART at the end of the quarter (current) (disaggregated by age, gender and pregnancy status)
8.18 Number of health workers trained to deliver ART services
8.19 Number of health workers trained to deliver HIV palliative care (non-ART)
8.19A Number trained to provide TB treatment to HIV-infected individuals (subset of above)
8.20 Number of individuals in cohort (6 and 12 month cohorts)
8.21 Number in cohort who have CD4+ counts (6 and 12 month cohorts)
8.22 Number in cohort who received ARVs for entire time period (6 and 12 month cohorts)
8.23 Median CD4+ count for cohort (6 and 12 month cohorts)
8.24 Number of patients on each regimen at the end of the quarter (by age)
8.25 Number of persons who started on ART at the facility in the PEPFAR programme who were not on ART at the end of the quarter
Activities in Support of ART Services
8.26 Number of HIV-infected individuals provided with ARV treatment at the end of the reporting period (indirect)
8.27 Number of health workers trained to deliver ART services
8.28 Number of hours of technical assistance provided for ART services
LABORATORY, POLICY/SYSTEM STRENGTHENING AND STRATEGIC INFORMATION
Laboratory Infrastructure
9.1 Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests
9.2 Number of tests performed at USG supported laboratories 1) HIV testing; 2) TB diagnostics; 3) syphilis testing; and 4) HIV disease monitoring
9.3 Number of individuals trained in the provision of laboratory related activities
Policy analysis and system strengthening
10.1 Number of local organizations provided with technical assistance for HIV-related policy development
10.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building
10.3 Number of individuals trained in HIV-related policy development
10.4 Number of individuals trained in HIV-related institutional capacity building
10.5 Number of individuals trained in HIV-related stigma and discrimination reduction
10.6 Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment
Strategic Information
11.1 Number of local organizations provided with technical assistance for strategic information
11.2 Number of individuals trained in strategic information
11.3 Number of hours of technical assistance provided for strategic information

Abstinence and Be Faithful

Programme Overview

One of the PEPFAR goals is the prevention of 7 million HIV infections by 2010. Abstinence and faithfulness programmes are a key intervention in reaching this goal.

Abstinence and faithfulness programmes are activities or programmes that promote abstinence combined with the importance of faithfulness in reducing the transmission of HIV among individuals in long-term sexual partnerships. These programmes include the following elements: elimination of casual sex and multiple sexual partnerships; development of skills for sustaining marital fidelity; adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships.

Activities or programmes that *only* promote the importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals include the following elements: decision of unmarried individuals to delay sexual activity until marriage; development of skills in unmarried individuals for practicing abstinence; and adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals.

Community outreach programmes are those that have as their primary behavioral objective the dissemination of abstinence and/or being faithful messages. Community outreach programmes could include community mobilization, peer education, classroom, small group and/or one-on-one information, education, and communication (IEC) and behavior change communication (BCC) messages/programmes to promote abstinence and/or being faithful. If programme content primarily addresses being faithful messages, such as one aimed at married men, it would count here.

Activities or programmes that promote abstinence must include at least one of the following components:

- Importance of abstinence in reducing the risk of HIV transmission among unmarried individuals;
- Decision of unmarried individuals to delay sexual activity until marriage;
- Development of skills in unmarried individuals for practicing abstinence; and
- Adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals.

Activities or programmes that promote being faithful must include at least one of the following components:

- Importance of being faithful in reducing the transmission of HIV among individuals in long-term sexual partnerships;
- Elimination of casual sex and multiple sexual partnerships;
- Development of skills for sustaining marital fidelity;
- Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and
- Adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships.

- Gender messaging supporting behavior change to reduce violence, coercion and multiple partners

Please see OGAC "ABC guidance" for further detail.

Indicators

1.1 The number of individuals reached through community outreach that promotes HIV prevention through abstinence and/or being faithful (disaggregated by gender)

Definition: The number of individuals reached through community outreach that promotes abstinence and/or being faithful. Community outreach is defined as any effort to effect behavior change that might include peer education, classroom, small group and/or one-on-one IEC or BCC. Community outreach does not include any messages disseminated by radio or media, but should be face-to-face. This data should be reported as a total, and then separately by number of males reached and number of females reached..

Rationale/what it measures: Community outreach is an important programmatic strategy for reaching the target population at the community level. This indicator measures the number of individuals who attended community outreach activities focused on abstinence and/or being faithful and must be reported separately for males and females. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.

Inclusions/exclusions: If the programme has a condomize message that is an equal or greater part of the behavior change campaign, it should be included under Condoms and Other Prevention rather than AB (see indicator 2.2)

Strengths and weaknesses: This indicator measures any changes in the number of people reached, indicating overall reach of the message. However, this indicator does not provide any indication of the quality of the community outreach nor does it indicate the coverage of a given community outreach programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through community outreach (coverage). The number of people reached also does not indicate whether behavior in these individuals actually changed.

1.1.A The number of individuals reached through community outreach that promotes HIV prevention through abstinence (subset of 1.1) (disaggregated by gender)

Definition: The number of individuals reached through community outreach that promotes abstinence (subset of the number of individuals reached with abstinence and/or being faithful messages). Community outreach is defined as any effort to effect change that might include peer education, classroom, small group and/or one-on-one IEC or BCC. Community outreach does not include any messages disseminated by radio or media, but should be face-to-face. This data should be reported as a total, and then by number of males reached and number of females reached separately.

Rationale/what it measures: Community outreach is an important programmatic strategy for reaching the target population at the community level. This indicator measures the number of individuals who attended community outreach activities focused on abstinence and must be reported separately for males and females. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.

Inclusions/exclusions: This is a subset of indictors 1.1. If the programme includes a being faithful message then it should be included under indicator 1.1 only.

Strengths and weaknesses: Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in the number of people reached, indicating further overall reach of the message. However, this indicator does not provide any indication of the quality of the community outreach nor does it indicate the coverage of a given community outreach programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through community outreach (coverage). The number of people reached also does not indicate whether behavior in these individuals actually changed.

1.2 Number of individuals trained to promote HIV prevention programmes through abstinence and/or being faithful

Definition: The number of individuals trained in implementing programmes that promote abstinence and/or being faithful. Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies. An individual should only be counted once they have completed the training. Individuals that are mid-way through a training course should be counted in the next reporting period. Individuals attending more than one training in a particular program area during a reporting period should only be counted once.

Rationale/what it measures: This indicator is a measure of peer or health educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of individuals who are able to deliver HIV prevention messages with a primary focus on abstinence and/or being faithful.

In many countries, the national AIDS coordination body and/or professional organizations have defined training standards. This applies in particular to countries that have introduced certification systems for HIV/AIDS training. The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programmes in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: If the training programme promotes behavior change through a condomize message that is an equal or greater part of the behavior change campaign, it should be included under Condoms and Other Prevention rather than AB (see indicator 2.2). Indicator 1.2 and 2.2 are mutually exclusive and the same individual cannot be counted under both indicators.

Strengths and weaknesses: This indicator is useful in that it tracks the number of peer and/or health educators trained to provide community outreach services to prevent HIV infection. The indicator attempts to document increasing capacity to deliver prevention interventions, however, no conclusion should be drawn regarding the quality of training nor does it measure the outcomes of the training in terms of competencies of the individuals trained or their job performance.

1.3 Number of hours of technical assistance provided for abstinence and/or being faithful programmes to: 1) National Government; 2) Local or Provincial Government; and 3) Other NGOs

Definition: The number of person hours of technical assistance provided by the PEPFAR-supported partners to improve the implementation of abstinence and/or being faithful programmes. Programmes can be implemented by national government entities, local or provincial government entities, or NGOs. Technical assistance (TA) is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of programmes in the specified area. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula with the goal of improving programme quality such as curriculum development for training of community outreach workers or developing messages for IEC material.

Rationale/what it measures: This indicator measures the amount of technical assistance provided by USG funded technical experts in the area of abstinence and/or being faithful programmes to governmental and non-governmental partners. It reflects capacity building efforts to improve programmes and develop policies in this area.

Inclusions/exclusions: If the programme has a condomize message that is an equal or greater part of the behavior change campaign, it should be included under Condoms and Other Prevention (see indicator 2.4)

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator attempts to capture an input into a process, but does not indicate the quality of the technical assistance provided or if the intended output was achieved.

Condoms and Other Prevention

Programme Overview

Condoms and Other Prevention *beyond* abstinence and/or being faithful includes the targeting of behaviors that increase risk for HIV transmission such as engaging in casual sexual encounters, engaging in sex in exchange for money or favors, having sex with an HIV positive partner or one whose status is unknown, using drugs or abusing alcohol in the context of sexual interactions, and using intravenous drugs. Women, even if faithful themselves, can still be at risk of becoming infected by their spouse, regular male partner, or someone using force against them. Other high risk persons or groups include men who have sex with men (MSM) and workers who are employed away from home. This programme area could include targeted social marketing and/or the promotion of condoms to high risk groups.

Please see OGAC "ABC guidance #1" for further detail.

Indicators

2.1 Number of targeted condom service outlets

Definition: The number of condom service outlets that are supported at the service delivery level, i.e. where condoms are distributed to the public, as opposed to distribution to facilities. Condom service outlets are fixed distribution points or mobile units with fixed schedules providing condoms for free or for sale. Targeted refers to a target, or high risk, population. In a generalized epidemic, this could be considered the entire population.

Rationale/what it measures: This indicator provides a tangible measure of the potential reach and coverage of condom distribution to a given community as an important part of a comprehensive prevention message. Partners should count the number of distribution points at which condoms are available to their target population.

Inclusions/exclusions: Include only those service outlets that provide condoms at service outlets supported at least in part with USG resources. Do not include any outlets that only distribute to other health facilities.

Strengths and weaknesses: While the indicator gives a single summary figure of all outlets, the partner can collect the data so it can also be disaggregated by outlet type. This will provide invaluable information for programme managers, and for those seeking to improve the marketing of condoms. Outlets such as bars, places where young people congregate and other high transmission sites such as border areas may need to be identified through key informants. When there are serious disruptions to condom supply at the central level, the repercussions may be felt simultaneously at a large majority of venues. If the indicator is measured at this time, it will appear as though the peripheral distribution system is inadequate whereas in fact the fault lies at the central level. This indicator also does only capture USG supported sites, whereas in South Africa, most condom distribution happens through sole support of the government.

2.2 Number of individuals reached through community outreach that promotes HIV prevention through other behavior change beyond abstinence and/or being faithful (disaggregated by gender)

Definition: The number of individuals reached through community outreach that promotes HIV prevention beyond abstinence and/or being faithful. If the programme has a comprehensive ABC message whereby the condomize message is an equal part of the behavior change campaign, those individuals should be included in this indicator (the indicators for Condoms and Other Prevention and AB are mutually exclusive). The Condoms and Other Prevention programme area also includes individuals reached by HIV prevention programmes that focus on HIV prevention with discordant couples, programmes that target commercial sex workers (CSW), and the social marketing and/or promoting of condoms. This data should be reported as a total, and then by number of males reached and number of females reached separately.

Community outreach is defined as any effort to effect change that might include peer education, classroom, small group and/or one-on-one IEC or BCC. Community outreach does not include any messages disseminated by radio or media, but should be face-to-face.

Rationale/what it measures: Community outreach is an important programmatic strategy for reaching the target population at the community level. This indicator measures the number of individuals who attended community outreach activities focused on prevention beyond abstinence and/or being faithful and must be reported separately for males and females. In any prevention campaign, the more individuals who receive the message, the higher number who may make the behavioral changes involved.

Inclusions/exclusions: If the programme is primarily focused on abstinence/be faithful messages and less than half of the focus is on other prevention strategies, then it should be only included under abstinence and be faithful section.

Strengths and weaknesses: Countries will be able to monitor their success in these efforts by setting goals that include tangible increases in the number of people reached, indicating further overall reach of the message. However, this indicator does not provide any indication of the quality of the community outreach nor does it indicate the coverage of a given community outreach programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through community outreach (coverage). The number of people reached also does not indicate whether behavior in these individuals actually changed.

2.3 Number of individuals trained to promote HIV prevention through other behavior change beyond abstinence and/or being faithful

Definition: The number of individuals trained to implement programmes that promote HIV prevention through messages beyond abstinence and/or being faithful. Condoms and Other Prevention programmes include those that focus on HIV prevention with discordant couples, programmes that target CSWs, and the social marketing and/or promoting of condoms.

Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies. An individual should only be counted once they have completed the training. Individuals that are mid-way through a training course should be counted in the next reporting period. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Rationale/what it measures: This indicator is a measure of peer or health educators who have been trained in the delivery of prevention messages to the target audience. It measures the number of newly trained or retrained individuals who are able to deliver HIV prevention messages beyond abstinence and/or being faithful. The assumption is more trained people will result in further distribution of the message.

In many countries, the national AIDS coordination body and/or professional organizations have defined training standards. This applies in particular to countries that have introduced certification systems for HIV/AIDS training. The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programmes in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: If the programme is primarily focused on abstinence/be faithful messages and less than half is focused on condoms and other prevention strategies, then it should be only included under abstinence and be faithful section.

Strengths and weaknesses: This indicator is useful in that it tracks the number of peer and or health educators trained to provide community outreach services to prevent HIV infection. The indicator captures increasing capacity to deliver prevention interventions, however, no conclusion should be drawn regarding the quality of training nor does it measure the outcomes of the training in terms of competencies of the individuals trained or their job performance.

2.4 Number of hours of technical assistance provided for Condoms and Other Prevention programmes to: 1) National Government; 2) Local or Provincial Government; and 3) Other NGOs

Definition: The number of person hours of technical assistance provided by the PEPFAR-supported partner to improve the implementation of prevention programmes beyond abstinence and/or being faithful. Programmes can be implemented by national government entities, local or provincial government entities, or other NGOs. Technical assistance (TA) is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of programmes in the specified area. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Rationale/what it measures: This indicator measures the amount of technical assistance provided by USG supported technical experts in the area of prevention beyond abstinence and/or being faithful programmes to governmental and non-governmental partners. It reflects capacity building efforts to improve programmes and develop policies in this area.

Inclusions/exclusions: If the programme is primarily focused on abstinence/be faithful messages and less than half is focused on condoms and other prevention strategies, then it should be only included under abstinence and be faithful section.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator attempts to capture an input into a process, but does not indicate the quality of the technical assistance provided or if the intended output was achieved.

Medical Transmission/ Blood Safety and Injection Safety

Programme Overview

Prevention of HIV transmission through medical practices is receiving increasing attention. Prevention programmes are implemented to prevent transmission through blood safety and injection safety programmes.

A national coordinated blood safety programme includes the following activities: policies, infrastructure, equipment, and supplies; donor recruitment activities; blood collection, distribution/supply chain/logistics, testing, screening, and transfusion; waste management; training; and management to ensure a safe and adequate blood supply.

Activities to promote medically related injection safety include: policies, training, waste management systems, advocacy, distribution/supply chain/logistics, appropriate disposal of injection equipment, and other related equipment and supplies.

Indicators

3.1 Number of service outlets carrying out blood safety activities

Definition: The number of service outlets carrying out blood safety activities. A service outlet refers to the lowest level of service, for example, a hospital, clinic, or mobile unit. Blood safety activities include those that support policies, infrastructure, equipment, and supplies; blood donor recruitment. Activities include; blood collection, distribution/supply chain/logistics, testing, screening, and/or transfusion; waste management; training; and/or management to ensure a safe and adequate blood supply.

The unit of measurement is the site, not the activity. A site will only count once during a reporting period regardless of the number of ongoing activities at the site.

Rationale/what it measures: This indicator counts the number of service outlets that receive direct USG support for blood safety activities. It measures the extent of support for reducing medical transmission of HIV through blood.

Inclusions/exclusions: Sites that do not receive direct USG support should be excluded.

Strengths and weaknesses: This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This indicator is not a complete measure of coverage, as there is no denominator of total facilities. In addition, this does not capture non-USG supported service outlets.

3.2 Number of individuals trained in blood safety

Definition: The number of individuals trained in blood safety. Blood safety training may address any of the following specific blood safety activities: blood safety policies, infrastructure, equipment, and supplies;

blood donor recruitment; blood collection, distribution/supply chain/logistics, testing, screening, and/or transfusion; waste management; and management to ensure a safe and adequate blood supply.
Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when these exist the training must follow a curriculum that indicates the objectives and/or expected competencies. Training may be knowledge and/or skills and/or competency-based.

Rationale/what it measures: The intent of the indicator is to measure progress toward a creating cadre of professionals trained in blood safety activities according to South African or international standards.

Each USG agency and USG funded partner counts the number of individuals trained in blood safety by USG staff (HQ or field-based) or USG funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report). Only participants who complete the full training course should be counted. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Inclusions/exclusions: Only include individuals who completed the training in blood safety as operationally defined by the organization.

Strengths and weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

3.3 Number of individuals trained in medical injection safety

Definition: The number of individuals trained in medical injection safety. Medical injection safety training may address any of the following specific medical injection safety activities: medical injection safety policies; appropriate disposal of injection equipment; waste management systems; and/or other injection safety related distribution/supply chain/logistics.

Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards. The training must follow a curriculum that indicates the objectives and/or expected competencies. Training may be knowledge and/or skills and/or competency-based.

Rationale/what it measures: The intent of the indicator is to measure progress toward a cadre of professionals trained in medical injection safety activities according to South African or international standards. The assumption is more trained people will result in better services.

Each USG agency and USG funded partner counts the number of individuals trained in medical injection safety by USG staff (HQ or field-based) or USG funded partners during the specified reporting period (6 months for semi-annual report/12 months for annual report). Only participants who complete the full training course should be counted. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Inclusions/exclusions: Only include individuals who completed the training in injection safety as operationally defined by the organization.

Strengths and weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

3.4 Number of facilities with good waste management and procurement systems to support injection safety

Definition: The number of public and private hospitals with good waste management and procurement systems to support injection safety in place. A good waste management and procurement system is determined through accreditation by the Council for Health Service Accreditation of Southern Africa (COHSASA).

Rationale/what it measures: This indicator measures the quality of waste management and procurement systems in hospitals. Waste management and procurement systems are essential for good HIV prevention and AIDS care service delivery.

Inclusions/exclusions: Only hospitals (public and private) that have been assessed and accredited by COHSASA should be included.

Strengths and weaknesses: This indicator does not consider the waste management and procurement systems of lower level facilities such as clinics and community health centres. This indicator is not a complete measure of coverage, as there is no denominator with the total number of hospitals.

3.5 Number of public health facilities (clinics and hospitals) receiving IEC printed material on injection safety and infection control

Definition: The number of public hospitals, clinics or community health centres receiving printed IEC material from the project on the following areas: universal and/or standard precautions, adherence to injection safety standards; use of personal protective equipment, types of health care waste, appropriate segregation and disposal of health care waste.

Rationale/what it measures: This indicator is one measure of the information received by facilities on injection safety and infection control. Personnel working in facilities need to have access to up-to-date information on injection safety and infection control methods and this indicator measures access to one source of information.

Inclusions/exclusions: Only public health facilities that received IEC material on injection safety and infection control should be included.

Strengths and weaknesses: This indicator does not consider the quality of the information provided by the IEC printed material, which would require more in-depth evaluation efforts. This indicator is not a complete measure of coverage, as there is no denominator with the total number of hospitals.

Prevention of Mother-To-Child Transmission

Programme Overview

Mother-to-child transmission (MTCT) of HIV can occur during pregnancy, labor, delivery, or after birth, through breastfeeding. Without intervention, it is estimated that the rate of MTCT is approximately 35% in developing countries. MTCT can be prevented by administering prophylactic treatment in the last weeks of pregnancy or at labor and delivery and by modification of infant feeding practices among HIV-infected women. Clinical trials have demonstrated that these interventions can reduce the risk of MTCT to between 2% and 20%, depending on the interventions used.

One of the PEPFAR goals is the prevention of 7 million HIV infections by 2010. The prevention of HIV infections in infants is an essential component of this goal. Unlike many prevention efforts, prevention of mother-to-child transmission (PMTCT) provides an opportunity for quantification of infections averted through monitoring the number of women who receive PMTCT interventions of known efficacy.

Indicators

4.1 Number of service outlets providing the minimum package of PMTCT services according to South African or international standards

Definition: The number of service outlets, such as antenatal clinic or other delivery site directly supported with USG resources (i.e. at the point of service delivery) that provide a minimum package to prevent mother-to-child transmission of HIV/AIDS. Include only those service outlets that provide the minimum package of PMTCT services including:

- Counseling and testing services;
- ARV prophylaxis to prevent MTCT;
- Counseling and support for safe infant feeding practices; and
- Family planning counseling or referral.

In order for a service outlet to be counted as providing the minimum package of PMTCT services, they must offer all four of the services listed above.

Rationale/what it measures: This indicator is specifically intended to capture service outlets supported at least in part with USG technical or financial resources. USG support includes provision of (1) direct funding; (2) personnel support; (3) materials/commodities; and/or (4) technical assistance.

Inclusions/exclusions: Include only those service outlets that provide the minimum package of PMTCT services listed above. Include only those facilities supported at least in part with USG resources.

Strengths and weaknesses: This indicator measures the extent of PEPFAR support for direct PMTCT services. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This indicator is not a complete measure of coverage, as there is no denominator with the total number of hospitals, and in most cases, a PMTCT service outlet consists of a clinic and hospital, with part of the service being offered at the clinic and part at the hospital.

4.2 Number of pregnant women that attended first antenatal care visit

Definition: The number of pregnant women who attended their first antenatal care (ANC) visit at a service outlet that offers PMTCT services supported by USG.

Rationale/what it measures: This indicator provides the number of pregnant women who access ANC services prior to giving birth (at a USG supported ANC service outlet). This figure can provide an estimate of the number of women who should be provided with pre-test counseling and HIV testing and thus serve as a denominator for coverage estimates of such services.

Inclusions/exclusions: Count only those pregnant women who received ANC services for the first time during the specified reporting period (6 months for semi-annual report / 12 months for annual report), even if they did not chose to access CT or PMTCT services.

Strengths and weaknesses: This indicator is not an expression of service uptake at a population level, but only the uptake of services at USG supported PMTCT service outlets. It also does not indicate uptake of PMTCT services, but provides an estimate as to how many women could access PMTCT.

4.3 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results

Definition: The number of pregnant women who received their HIV test results and were post-test counseled at a USG directly supported PMTCT service outlet. A service outlet is the lowest level of service delivery and USG support includes provision of (1) direct funding; (2) personnel support; (3) materials/commodities; and/or (4) technical assistance.

Rationale/what it measures: This indicator reflects a primary goal of PMTCT, which is to increase the number of pregnant women who know their HIV status.

Inclusions/exclusions: Count only those pregnant women who received, at minimum, HIV counseling and testing and received results during the specified reporting period (6 months for semi-annual report / 12 months for annual report). This is not dependent on the results; i.e.: this includes women who test negative as well.

Strengths and weaknesses: This indicator is not an expression of service uptake at a population level, but only the uptake of services at USG supported PMTCT service outlets. The goal is to track the number of pregnant women who received their test results, however, not all programmes are set up to adequately distinguish between those who are tested and those who receive results. In order to provide good quality services, all USG funded PMTCT sites should work toward tracking women through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions.

4.4 Number of pregnant women provided with a complete course of ARV

Definition: The number of HIV-infected pregnant women who received ARV prophylaxis and counseling for PMTCT at a USG supported PMTCT service outlet. ARV prophylaxis may be single dose Nevirapine (SD NVP) or short-course combination prophylaxis or highly active antiretroviral therapy (HAART). The PMTCT sites must follow current South Africa-specific protocols. (Since these may change over time, please consult the national or provincial Department of Health for PMTCT guidelines.) Counseling could

include, but is not limited to nutrition advice for both the infant and mother, psychosocial support, and counseling regarding long-term wellness and ARV treatment options.

Rationale/what it measures: This indicator is a measure of the delivery and uptake of antiretroviral prophylaxis for PMTCT, which is the key intervention to prevent infection of the child.

Inclusions/exclusions: Only HIV-infected pregnant women should be included in this indicator.

Strengths and weaknesses: This indicator is not an expression of service coverage at a population level, but only the delivery/uptake of services at USG supported PMTCT service outlets. This indicator does not distinguish among the different types of prophylaxis (SD NVP, short-course prophylaxis, HAART). It is recommended to track the different types of prophylaxis. This indicator may overestimate the number of women who have received a complete course due to the fact that it is not always administered at the facility. It also does not necessarily allow for an estimate of effectiveness if data systems are not set up to verify this information.

4.5 Number of infants receiving an ARV prophylaxis

Definition: The number of infants (born to HIV-infected women) who received an ARV prophylaxis for PMTCT at a USG supported PMTCT service outlet.

Rationale/what it measures: This indicator is a measure of the delivery and uptake of ARV prophylaxis for infants, because it is a key intervention to prevent HIV infection.

Inclusions/exclusions: Count only those infants born to HIV-infected mothers during the specified reporting period (6 months for semi-annual report / 12 months for annual report). This is not dependent on whether the mother received an ARV prophylaxis as well, but is a separate data set.

Strengths and weaknesses: This indicator measures the extent of PMTCT service uptake from first identifying the mother's HIV status to providing the baby with ARV prophylaxis. It does not, however, measure the effectiveness of the prophylaxis itself.

4.6 Number of infants tested by PCR at 6-14 weeks

Definition: The number of infants (born to HIV-infected women) who were tested for HIV by DNA polymerase chain reaction (PCR) at *approximately* 6-14 weeks after birth.

Rationale/what it measures: This indicator measures the number of infants who were tested for HIV at 6-14 weeks by PCR, as this is a more accurate measure of HIV status in an infant. This is also an important step in the PMTCT intervention and also to link the infant into further care if needed. If infants are still being breastfed repeat testing will be necessary to confirm HIV status.

Inclusions/exclusions: Count only those infants born to HIV-infected mothers during the specified reporting period (6 months for semi-annual report / 12 months for annual report) that received a specific PCR test. Exclude other testing methods. Also, only count those infants tested around the 6-14 week after birth timeframe (with a 3 week window on each side).

Strengths and weaknesses: The indicator intends to measure the extent that babies born to HIV positive women are brought back to the health facility to be tested for HIV soon after birth. It does not detect the mode of transmission for babies who test HIV positive.

4.7 Number of infants tested at 12 months

Definition: The number of infants (born to HIV-infected women) who were tested for HIV at *approximately* 12 months after birth. This indicator is not specifying testing method, so can capture various types of testing. Approximately indicates that it can be anywhere between 11 and 13 months.

Rationale/what it measures: Follow-up testing is an important step in the PMTCT intervention and also to link the infant into further care if needed. Follow-up testing is also necessary to monitor the effectiveness of the PMTCT programme. The reason for conducting the test at 12 months is that the infant no longer has maternal antibodies to HIV. In most cases, infants enrolled in the PMTCT programme are weaned at 4-6 months. HIV transmission from mother-to child usually occurs within the first 12 months after birth. Therefore, testing at 12 months can accurately detect mother-to-child transmission rates.

Inclusions/exclusions: Count only those infants born to HIV-infected mothers during the specified reporting period (6 months for semi-annual report / 12 months for annual report) that received an HIV test. Also, only count those infants tested around the 12 month after birth timeframe (with a 1 month window on each side).

Strengths and weaknesses: This indicator intends to measure the extent that babies born to HIV positive women are brought back to health facilities to be tested for HIV. However, it does not capture whether babies had been previously tested for HIV and therefore cannot detect the mode of transmission for babies who test HIV positive.

4.8 Number of HIV-infected pregnant women referred to: 1) a wellness programme and 2) a treatment programme

Definition: The number of HIV-infected pregnant women who were referred for wellness programmes and HIV/AIDS care or treatment services. Wellness programmes include: symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management (and/or referral for these) of opportunistic infections such as TB/HIV, malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; and social and material support, such as nutrition support, legal aid, and housing. A treatment programme would include the provision of antiretroviral drugs and clinical monitoring.

Rationale/what it measures: As soon as women are diagnosed as HIV-infected, they may need to be referred for a range of wellness and/or treatment services. The women will stay much healthier if they have care and support from an early stage. PMTCT may be a method of identifying women early. This indicator provides an estimate of the number of women who are referred to such services from the PMTCT programme.

Inclusions/exclusions: Count only HIV-infected pregnant women who were provided referrals for a wellness programme and/or treatment programme.

Strengths and weaknesses: This indicator only counts those who are referred and does not assess whether the women actually received the services.

4.9 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results (indirect)

Definition: The estimated number of women who received HIV counseling and testing and received their results in a PMTCT setting regardless of their status. Indirect support includes: national, provincial, or district level policy development; institutional capacity building; logistics; protocol or guideline development; advocacy; national, provincial, district level training; or national, provincial, or district level management information systems.

Rationale/what it measures: There are a number of support functions that are essential for the provision of quality PMTCT services. This indicator tries to account for all these activities of USG funded partners by estimating the number of women who received counseling and testing for PMTCT that benefited from indirect support.

Inclusions/exclusions: This is an estimate of the reach on the indirect support for PMTCT often at provincial or national levels. Only include those pregnant women who received counseling and testing and received their test results for PMTCT. They do not have to have received ARV prophylaxis to be included.

Strengths and weaknesses: This indicator captures indirect support at the provincial or national level that aims to strengthen PMTCT services that are not at the service delivery level. It does not measure the quality of the support provided, and it is difficult to determine the contribution or effect of the support for overall PMTCT services.

4.10 Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting (indirect)

Definition: The estimated number of women who have received ARV prophylaxis in a PMTCT setting through indirect USG support. ARV prophylaxis may be single dose Nevirapine (SD NVP) or short-course combination prophylaxis or highly active antiretroviral therapy (HAART). Indirect support includes: national, provincial, or district level policy development; institutional capacity building; logistics; protocol or guideline development; advocacy; national, provincial, district level training; or national, provincial, or district level management information systems. See page 25 for further detail.

Rationale/what it measures: There are a number of support functions that are essential for the provision of quality PMTCT services, including ARV prophylaxis. This indicator tries to account for all these activities of USG funded partners by estimating the number of women who received ARV prophylaxis within a PMTCT programme that benefited from indirect support.

Inclusions/exclusions: This is an estimate of the reach on the indirect support for PMTCT often at provincial or national level. Only include those pregnant women who received ARV prophylaxis. If they have accessed other PMTCT services, but did not continue all the way through to receive the ARV prophylaxis, they should not be counted under indicator 4.10.

Strengths and weaknesses: This indicator captures indirect support at the provincial or national level that aims to strengthen PMTCT services that are not at the service delivery level. Because it is indirect it is an

estimate, not actual reported data. It also does not measure the quality of the support provided, and it is difficult to determine the contribution or effect of the support for overall PMTCT services.

4.11 Number of health workers trained in the provision of PMTCT services according to South African or international standards

Definition: The number of health workers who completed, during the reporting period, a course or training workshop sponsored, co-sponsored, or conducted by USG funded partners to provide or improve delivery of PMTCT services. This includes health workers that are newly trained and those retrained. USG support includes provision of (1) direct funding; (2) personnel support; (3) materials/commodities; and/or (4) technical assistance, or similar support by USG funded partners.

To be considered here, the training must contain at least one of the PMTCT core elements: PMTCT-related counseling and testing, ARV prophylaxis, infant feeding counseling, and family planning counseling or referral.

Rationale/what it measures: This indicator is specifically intended to capture training that was supported at least in part with USG technical or financial resources. The assumption is that training will result in increased human resource capacity to improve and expand access to services. This indicator will indicate progress towards this goal.

Inclusions/exclusions: Both in-service and pre-service trainings and workshops are included. Only participants who complete the full training course should be counted. If the participant is in the middle of the course, they should be counted in the subsequent reporting period. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Strengths and weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures the number trained in PMTCT as opposed to an indicator such as the percent of health facilities with trained staff, which indicates coverage. This may be measured through health facility surveys.

4.12 Number of hours of technical assistance provided for PMTCT programmes to: 1) National Government; 2) Local or Provincial Government; and 3) Other NGOs

Definition: The number of person hours of technical assistance provided by the PEPFAR-supported partner to local NGOs, national or provincial Departments of Health, or other institutions for strengthening PMTCT services.

Technical assistance (TA) is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of programmes in the specified area. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

PMTCT services include: counselling and testing for pregnant women; ARV prophylaxis to prevent MTCT; counselling and support for safe infant feeding practices; and family planning counselling or referral.

Rationale/what it measures: This indicator measures the amount of technical assistance provided by USG technical experts in the area of PMTCT programmes to governmental and non-governmental partners. It reflects capacity building efforts to improve programmes and develop policies in this area.

Inclusions/exclusions: Include person hours of technical assistance provided.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator attempts to capture an input into a process, but does not indicate the quality of the technical assistance provided or if the intended output was achieved.

Counseling and Testing

Programme Overview

Since 2000, the South African NDOH has supported widespread implementation of a National Programme for HIV counseling and testing (CT), establishing national policies, procedures, guidelines and legislating intervention strategies to provide universal access to the adult population. NDOH and other stakeholders are exploring the use of routine and diagnostic testing as a means to increase access to CT and ensure linkages to care and treatment programmes. PEPFAR partners are encouraged to recommend CT to all clients on a routine basis.

Counseling and testing is a key gateway for HIV prevention, care and treatment. With the expansion of HIV-related treatment in South Africa the role of CT in identifying and referring those in need of HIV-related services is essential. It is imperative to strengthen linkages and referral networks between CT, TB, PMTCT, STI, family planning, palliative care and ARV services.

Counseling and testing (CT) includes activities in which both HIV counseling (pre and post-test) and testing are provided for those who want to know their HIV status (as in traditional voluntary counseling and testing (CT)) or, as indicated in other contexts, such as in STI clinics or TB centres, where HIV diagnosis is confirmed. Counseling and testing in a PMTCT setting is covered under PMTCT.

Indicators

5.1 Number of service outlets providing counseling and testing according to South African or international standards

Definition:
A service outlet refers to the lowest level of service – where the testing is actually completed. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a health centre, hospital, clinic, stand alone CT centre, or mobile unit. Counseling and testing includes activities in which both HIV counseling and testing are provided for those who seek to know their status (as in traditional CT) or as indicated in other contexts such as STI clinics or diagnostic testing. This indicator excludes service outlets that provide counseling and testing in the context of preventing mother-to-child transmission. Please refer to indicator 4.1 for more guidance on reporting the number of service outlets that provide services to prevent mother-to-child transmission of HIV.

Rationale/what it measures: This indicator provides a gross count of the number of USG supported locations that provide basic counseling and testing for HIV. It provides a rough sense of coverage of counseling and testing services. If there is a plan to expand the number of service outlets, this measure will track the progress of meeting that goal.

Inclusions/exclusions: Include only those facilities supported, at least in part, with USG resources. Counseling and testing for PMTCT should be included in the PMTCT programme area only. HIV counseling and testing specifically targeting TB patients should be included in the TB/HIV programme area only.

Strengths and weaknesses: This is purely an output measure. It provides no sense of the geographical spread of CT services, nor any relationship to the percentage of the population that is reached by the service outlet. This indicator does not consider the quality of service provision, which would require more in-depth

evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.

5.2 Number of individuals pre-test counseled (disaggregated by gender)

Definition: The number of clients that received individual counseling prior to testing for HIV at a USG supported CT site (e.g. hospitals, clinics, stand alone CT centres, mobile unites, etc.).

Rationale/what it measures: This indicator reflects the first step in reaching one goal of CT that is to increase the number of individuals who know their HIV status. Pretest counselling is an important first step in learning ones' HIV status.

Inclusions/exclusions: Count only those individuals who received HIV pre-test counseling during the specified reporting period (6 months for semi-annual report / 12 months for annual report).

Strengths and weaknesses: This indicator is not an expression of service uptake at a population level, but only the uptake of services at USG supported CT service outlets. The goal is to track the number of individuals who received pre-test counselling. In order to provide good quality services, all USG funded CT sites should work toward tracking individuals through pre-test counseling, testing, post-test counseling, provision of results, and subsequent interventions.

5.3 Number of clients who received counseling and testing and received their test results (disaggregated by gender)

Definition: The number of clients that received HIV test results and post-test counseling at a USG supported CT site such as hospitals, clinics, stand-alone CT centres and mobile units. This is a subset of those who were tested for HIV. This indicator requires a minimum of post-test counseling, testing, and the provision of test results. This data should be reported as a total, and then by number of males reached and number of females reached separately.

Rationale/what it measures: This indicator provides a count of those individuals who have received counseling and testing during the current reporting period and are now aware of their HIV status. The hope is that knowledge of one's status leads to appropriate behavior change and access to services if necessary.

Inclusions/exclusions: Only those whose confirmed HIV test status is known can be counted. If they test and do not return, they are excluded. If a client does not receive the appropriate post-test counseling, they also should be excluded.

Strengths and weaknesses: Not all those who are tested will return for results, thus there will be a loss to follow-up. This indicator also does not indicate quality or coverage of services. It is also limited to USG-supported sites, and is not a national number.

5.4 Number of clients who received counseling and testing and received their test results (indirect)

Definition: The estimated number of individuals who received HIV test results and post-test counseling through indirect support. Indirect support includes any of the following: national, provincial, or district level policy development; institutional capacity building; logistics; protocol or guideline development; advocacy; national, provincial, or district level training; and national, provincial, or district level management information systems. See page 25 for further detail.

Rationale/what it measures: There are a number of support functions that are essential for the provision of quality CT services. This indicator tries to estimate the results of USG supported partners who indirectly contribute to increasing access or quality of CT services.

Inclusions/exclusions: Count only services that received indirect support. Those services that received direct support should be counted in indicator 5.4.

Strengths and weaknesses: There may be some facilities that receive both direct and indirect support. This is also an estimate and not actual reported data.

5.5 Number of HIV-infected individuals referred to a: 1) wellness programme 2) treatment programme; 3) STI services; 4) TB services

Definition: The number of individuals identified as HIV-infected through a CT programme that were then referred for HIV care or treatment. Wellness programmes could include: symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management (and/or referral for these) of opportunistic infections (including TB/HIV) including malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; and social and material support, such as nutrition support, legal aid, and housing. A treatment programme would include the provision of antiretroviral drugs and clinical monitoring. STI are facilities that have the capacity to diagnose and treat sexually transmitted infections. TB services are those facilities that provide TB diagnostics and treatment.

Rationale/what it measures: Once diagnosed as HIV-infected, individuals may need to be referred for a range of wellness and/or treatment services. The earlier that HIV-infected individuals access care and treatment, the longer they will stay healthy. This indicator provides an estimate of the number of individuals who are referred to such services.

Inclusions/exclusions: Count only individuals tested positive for HIV who were referred to either:
1) wellness programme 2) treatment programme; 3) STI services; or 4) TB services. Individuals can be counted in each of the referral categories.

Strengths and weaknesses: This indicator only counts those who are referred and does not assess whether the individuals actually accessed or received the services. It is recommended that programmes have an active referral tracking system to obtain such information. Although only referrals to wellness, treatment, STI and TB programmes are tracked in this indicator, partners are encouraged to refer to a wide variety or appropriate services, including services for individuals who test negative, and monitor such referrals as part of regular programme management.

5.6 Number of individuals trained in counseling and testing according to South African or international standards

Definition: The number of individuals trained to provide HIV counseling and testing services. Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies. An individual should only be counted once they have completed the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

This indicator is specifically intended to capture training that was supported at least in part with USG technical or financial resources. USG support includes provision of (1) direct funding; (2) personnel support; (3) materials/commodities; and/or (4) technical assistance, or similar support by USG funded partners.

Rationale/what it measures: Training increases the number of professionals able to carry out counseling and testing services. It also should increase quality. This gives some indication of this increased capacity.

Inclusions/exclusions: Only participants who complete a full training course should be counted.
If a training course covers more than one topic within the CT programme area, individuals should only be counted once for that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training event.

Strengths and weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures the number trained in CT as opposed to an indicator such as the percent of health facilities with trained staff, which may indicate coverage. This may be measured through health facility surveys.

5.7 Number of hours of technical assistance provided on counseling and testing to: 1) National Government; 2) Local or Provincial Government; and 3) Other NGOs

Definition: The number of person hours of technical assistance provided by the PEPFAR-supported partners to local NGOs, national or provincial Departments of Health, or other institutions for building capacity to provide HIV counseling and testing services. Technical assistance is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of programmes in the specified area. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Rationale/what it measures: This indicator measures the amount of technical assistance provided by USG supported technical experts in the area of counseling and testing to governmental and non-governmental partners. It reflects capacity building efforts to improve programmes and develop policies in this area.

Inclusions/exclusions: Include person hours of technical assistance provided specifically for strengthening CT programmes and/or policies.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator attempts to capture an input into a process, but does not indicate the quality of the technical assistance provided or if the intended output was achieved.

Orphans and Vulnerable Children

Programme Overview

Current estimates indicate that in South Africa, 1.1 million children have been orphaned. The goal of orphans and vulnerable children (OVC) activities is to provide support aimed at improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality. The emphasis of OVC programmes is on strengthening communities to meet the needs of orphans and vulnerable children affected by HIV/AIDS, supporting community-based responses, helping children and adolescents meet their own needs, creating a supportive social environment. Activities could include training caregivers; increasing access to education; economic support; targeted food and nutrition support; legal aid; medical, psychosocial, or emotional care; and/or other social and material support.

Orphans are defined as children under 18 who have lost either a mother or father. Vulnerable children are those affected by HIV through the illness of a parent or principle caretaker. If an HIV-infected OVC is receiving ART treatment as well as care in an OVC programme, the OVC should be counted both under treatment ***and*** under OVC. However, an HIV-infected OVC receiving palliative care services among other services within an OVC programme should ***only*** be counted under OVC to avoid double counting under the total care count.

Indicators

6.1. Number of OVC served by an OVC programme (disaggregated by gender)

Definition: The number of unique OVC, under 18 years of age, provided with direct support during the defined reporting period. To be considered having received direct support, the OVC must receive at least three of the following nine services:

- Assisting with access to health care (including counseling and testing);
- Referral or provision of antiretroviral treatment;
- Assisting with access to education including school fees, uniforms or tutoring;
- Assisting with access to economic support such as accessing social grants, income generation projects;
- Providing food and/or nutrition support including supplements or food gardens;
- Providing legal assistance, including accessing birth certificates and succession planning;
- Providing or linking OVC to psychosocial support;
- Providing protection from abuse; and
- Mobilizing and building capacity of communities to respond to OVC needs.

This data should be reported as a total, and then by number of males reached and number of females reached separately. OVC can be counted in each of the subset indicators if they receive care in each different areas within the reporting period.

Rationale/what it measures: An OVC should be reached with a comprehensive package of services. Providing only food to a child in need is not sufficient, but they should be linked or provided with services to meet all their needs. This indicator provides a measure of the number of OVC that are receiving comprehensive services by using a minimum of three services out of a package of nine.

Inclusions/exclusions: Only those OVC who are being served by programmes that provide at least three types of OVC services are counted in this indicator. OVC 18 and older should be excluded from this indicator. Excludes children not considered an orphan or vulnerable child by the programme and/or community.

Strengths and weaknesses: This indicator measures the change in reach of comprehensive OVC programmes. However, this indicator does not provide any indication of the quality of the OVC services, including how many times a child accessed services nor does it indicate the coverage of a given OVC programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through OVC programmes.

6.1A Number of OVC receiving increased access to health care (subset of 6.1)

Definition: Number of OVC receiving increased access to health care. This includes the referral and/or provision of childhood immunization, routine exams, clinical monitoring and management and ARV therapy if necessary.

Rationale/what it measures: Ensuring continued access to health care is a basic need for OVC. Health care is generally free in South Africa and the OVC may just lack access. This intends to monitor that these linkages are being made within OVC programmes.

Inclusions/exclusions: Include only those OVC who have received direct support to access health care. Exclude OVC 18 years and older and those children not considered an orphan or vulnerable by the programme

Strengths and weaknesses: This indicator measures the changes in the reach of OVC programmes that provide access to health care. However, this indicator does not provide any indication of the quality of the OVC services nor does it indicate the coverage of a given OVC programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through health care programmes.

6.1B Number of OVC receiving antiretroviral treatment (subset of 6.1)

Definition: This indicator is specifically measuring the number of children orphaned or made vulnerable by HIV and AIDS, and are infected with HIV, who are receiving antiretroviral treatment. The OVC partner may not be providing ARVs themselves, but should ensure that the OVC gains access to ARVs as appropriate and assists them to monitor issues such as adherence and nutrition so the child remains healthy.

Rationale/what it measures: In South Africa, ARVs are rolling out at a national level. It is vital that HIV infected children gain access to these ARV programs so they are able to be healthy and productive. This indicator intends to monitor that the linkages are being made between OVC and ART programmes.

Inclusions/exclusions: Include only those OVC (under 18) who are receiving ARVs. Exclude OVC who are in pre-treatment training or those who are HIV positive, but are not yet eligible, until they are actually receiving ARVs. Exclude OVC who are 18 years of age or older.

Strengths and weaknesses: This indicator is an indication that children are gaining access to antiretroviral treatment. However, it does not capture the total number eligible for treatment and the percentage of children receiving treatment out of total in need. This indicator also does not indicate the quality of the treatment program or adherence to ARVs.

6.1C Number of OVC receiving support to increase access to education (subset of 6.1)

Definition: The number of OVC receiving support to access education. This could include either the provision of school fees or assisting the child in having school fees waived, providing a uniform, or either providing tutoring or ensuring that the child can access tutoring. This could also include advocacy activities aimed at district or provincial governments to ensure that policies are in place for all children to access education.

Rationale/what it measures: In South Africa, the law stipulates that all children must have access to free education. Education is also key to long-term development and success of a child. This intends to monitor that these linkages are being made within OVC programmes.

Inclusions/exclusions: Include only those OVC who have received direct support to increase access to education. Excludes children 18 and over, and those children not considered an orphan or vulnerable by the programme.

Strengths and weaknesses: This indicator measures changes in the reach of educational support programmes for OVC. However, this indicator does not provide any indication of the quality or the coverage of educational support programmes. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through educational support programmes for OVC.

6.1D Number of OVC receiving access to economic support (subset of 6.1)

Definition: The number of OVC that received access to economic support. Economic support is broad, but could include such interventions as accessing social grants or income generation projects. This could also include advocacy activities to ensure policies are supportive of OVC.

Rationale/what it measures: Many families affected by HIV/AIDS suffer economic losses. It is essential to monitor the number of OVC that receive access to economic services. This intends to monitor that these linkages are being made within OVC programmes.

Inclusions/exclusions: Include only those OVC who have received direct access to economic support. Exclude OVC 18 years and older and those children not considered an orphan or vulnerable by the programme.

Strengths and weaknesses: This indicator measures the changes in the reach of economic support programmes for OVC. However, this indicator does not provide any indication of the quality or the coverage of economic support programmes for OVC. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through economic support programmes for OVC.

6.1E Number of OVC receiving food or nutritional support (subset of 6.1)

Definition: The number of OVC that receive food or nutritional support could include nutritional supplements, feeding schemes at centres or food gardens, etc.

Rationale/what it measures: Ensuring continued access to food is a basic need for all OVC, and is key to ongoing development. This indicator intends to monitor that these linkages are being made within OVC programmes.

Inclusions/exclusions: Include only those OVC who have received direct support to nutritional or food support. Exclude OVC 18 years and older and those children not considered an orphan or vulnerable by the programme

Strengths and weaknesses: This indicator measures the changes in the reach of food and nutritional support programmes for OVC. However, this indicator does not provide any indication of the quality of the OVC services nor does it indicate the coverage of a given OVC programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through nutritional support programmes for OVC.

6.1F Number of OVC receiving legal assistance (subset of 6.1)

Definition: The number of OVC receiving legal assistance, including accessing birth certificates or addressing issues of inheritance.

Rationale/what it measures: Ensuring access to legal assistance is important for OVC as many may face difficult legal issues related to land rights, housing, and other rights that require legal assistance. This intends to monitor that these linkages are being made within OVC programmes.

Inclusions/exclusions: Include only those OVC who have received direct support to legal assistance. Exclude OVC 18 years and older and those children not considered an orphan or vulnerable by the programme

Strengths and weaknesses: This indicator measures the changes in the reach of legal assistance OVC programmes. However, this indicator does not provide any indication of the quality of the OVC services nor does it indicate the coverage of a given OVC programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through legal assistance programmes.

6.1G Number of OVC provided with or referred to psychosocial support (subset of 6.1)

Definition: Number of OVC that are directly provided with the appropriate psychosocial support care that meets their needs, or, a referral to the appropriate services that can address the needs. This includes age appropriate HIV prevention education, grief counseling, and other activities such as kids clubs and OVC support groups.

Rationale/what it measures: Ensuring access to psychosocial support care is important for OVC as many have experienced significant trauma. It is an important aspect of overall health. This intends to monitor that these linkages are being made within an OVC programme.

Inclusions/exclusions: Include only those OVC who have received direct psychosocial support. Exclude OVC 18 years and older and those children not considered an orphan or vulnerable by the programme.

Strengths and weaknesses: This indicator measures the changes in the reach of psychosocial support care services. However, this indicator does not provide any indication of the quality of the OVC services nor does it indicate the coverage of a given OVC programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached with psychosocial support.

6.1H Number of OVC provided with protection from abuse

Definition: Number of OVC that are at risk or have suffered from abuse that have been referred to protection services, or some type of protection has been arranged within the community.

Rationale/what it measures: There is increasing evidence that some OVC suffer abuse or are at risk of abuse due to their OVC status, especially in a child-headed household. It is important that these issues be addressed as part of a holistic package of services. This intends to monitor that these linkages are being made within OVC programmes.

Inclusions/exclusions: Include only those OVC who have received protection from abuse in some manner. Exclude OVC 18 years and older and those children not considered an orphan or vulnerable by the programme

Strengths and weaknesses: This indicator measures the changes in the reach of OVC programmes that provide protection from abuse. However, this indicator does not provide any indication of the quality of the OVC services nor does it indicate the coverage of a given OVC programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through abuse protections services.

It is very difficult to identify children who are at risk of or who have suffered from abuse. While it is very important to provide protection services for such OVC, their confidentiality must be ensured. For example, the child must agree to have their name given to a child protection agency.

6.1I Number of OVC benefiting from community mobilization to respond to OVC needs (subset of 6.1)

Definition: Number of OVC that are receiving services through programmes that are focused on mobilizing and building capacity of communities to respond to OVC needs.

Community mobilization activities include:

- Identifying social groups and mapping existing formal structures or networks in order to encourage or promote HIV prevention, care and/or treatment interventions and services, such as counseling and testing, PMTCT, HIV care and antiretroviral treatment;
- Building trust with the community by providing a forum to discuss their perceived needs for HIV prevention, care and/or treatment interventions and services;
- Developing communication around social networks to engage in dialogue with the community which encourages or promotes HIV prevention, care and/or treatment interventions and services; and

- Creating media and events that expose community members to new ideas, involving them in problem solving, and encouraging innovations that promote HIV prevention, care and/or treatment interventions and services.

Rationale/what it measures: Strengthening communities is a key strategy for improving the lives of children and families directly affected by AIDS-related morbidity and/or mortality.

Inclusions/exclusions: Include only those OVC who have received support through community networks. Exclude OVC 18 years and older and those children not considered an orphan or vulnerable by the programme.

Strengths and weaknesses: This indicator measures the changes in the reach of community mobilization efforts to respond to OVC needs. However, this indicator does not provide any indication of the quality of the OVC services nor does it indicate the coverage of a given OVC programme. If an estimate of the target population were known, then it would be possible to calculate the percentage of the target population reached through community mobilization efforts.

6.2 Number of OVC served by OVC programmes (indirect)

Definition: The number of OVC provided with indirect support. Indirect support is defined as those children reached with fewer than three of the following eight services:

- Assisting with access to health care (including counseling and testing);
- Referral or provision of antiretroviral treatment;
- Assisting with access to education including school fees, uniforms or tutoring;
- Assisting with access to economic support such as accessing social grants, income generation projects;
- Providing food and/or nutrition support including supplements or food gardens;
- Providing legal assistance, including accessing birth certificates and succession planning;
- Providing or linking OVC to psychosocial support;
- Providing protection from abuse; and
- Mobilizing and building capacity of communities to respond to OVC needs.

Rationale/what it measures: It is intended that OVC will be provided with a holistic package of services in order to meet all of their needs. However, there are other interventions that are necessary to implement OVC programmes such as policy and guideline development, advocacy and development of materials. Defining direct as more than three and indirect as less than three distinguishes these types of interventions, as well as encouraging those providing direct support to consider the OVC's multiple needs.

Inclusions/exclusions: Only those OVC who are being served by programmes that provide less than three types of OVC services are counted in this indicator. Exclude OVC 18 years and older and those children not considered an orphan or vulnerable by the programme

Strengths and weaknesses: This indicator measures the changes in the reach of indirect OVC programmes (i.e., those that provide fewer than three types of services). However, this indicator does not provide any indication of the quality of the OVC services nor does it indicate the coverage of a given OVC programme

6. 3 Number of family members of OVC provided with HIV-related palliative care

Definition: The number of family members of Orphans and Vulnerable Children (OVC) provided with palliative care services that are directly supported with USG funds (i.e. at the service delivery level). The minimum requirements for someone having received palliative care are that the individual must have received services in at least two categories of clinical, psychological, spiritual or social services. Please refer to the palliative care tables in Appendix B for an illustrative list of palliative care service.

Family member is defined as a legal spouse or common-law spouse (where legal), same or opposite sex domestic partner, legal guardian, legal ward, son or daughter (adopted*, foster*, step or in-law), brother or sister (adopted*, foster*, step or in-law), parent (includes step or in-law), grandparent (includes in-law), great-grandparent (includes in-law), grandchild, great-grandchild, aunt, uncle, niece, nephew, cousin or member of household of an HIV-infected individual that may or may not live in the same residence**.

**Adopted and foster relationships may include both legal and informal arrangements.*

***In the context of palliative care in Africa, home or household does not mean physical infrastructure in which a person lives, but also involves the biological, sociological and spiritual roots of an individual.*

Rationale/what it measures: Fundamental to the palliative approach to HIV care is actively engaging and supporting family members of OVC. Providing only one category of services is not sufficient, but families should be linked or provided with services to meet all their needs. As a result, at least two categories of services are required for a partner to count that they have delivered HIV-related palliative care services to OVC. This indicator is the total number of unduplicated family members of OVC, receiving care from USG supported facilities and/or community/home-based organizations. It is the goal of the South African government and PEPFAR to increase access of HIV services in the country. This indicator monitors progress towards this goal.

Inclusions/exclusions: Family members of OVC should be included if they received HIV-related palliative care in at least two categories of palliative care (listed in appendix B). Partners should not double count individuals within a program or service outlet, even if the individual accesses services on multiple occasions. Individuals receiving non-HIV related services should be excluded.

Family members who are infected with HIV and receiving HIV-related palliative care services should be excluded here and counted in indicator "Number of individuals provided with HIV-related palliative care (including TB) (disaggregated by gender)". If applicable, the HIV-infected family member may also be counted in the ARV Services Program Area.

Strengths and weaknesses: Adjusting for overlap between programs is very difficult, especially when programs are not well linked and patient confidentiality concerns must be respected. Some overcounting may occur. This indicator measures the change in reach of comprehensive palliative care programs. However, this indicator does not provide any indication of the quality of the services, including how many times PLWHA accessed services nor does it indicate the coverage of a given palliative care programme.

6.3 Number of providers/caretakers trained in caring for OVC

Definition: The number of individuals trained to provide services to OVC in any of the following areas:

- Assisting with access to health care (including counseling and testing);
- Referral or provision of antiretroviral treatment;

- Assisting with access to education including school fees, uniforms or tutoring;
- Assisting with access to economic support such as accessing social grants, income generation projects;
- Providing food and/or nutrition support including supplements or food gardens;
- Providing legal assistance, including accessing birth certificates and succession planning;
- Providing or linking OVC to psychosocial support;
- Providing protection from abuse; and
- Mobilizing and building capacity of communities to respond to OVC needs.

Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies. An individual should only be counted once they have completed the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Rationale/what it measures: This indicator is a measure of OVC caregivers who have been trained in the delivery of OVC services (one or more of the eight areas listed above) to OVC. There is a need to increase the cadre of caregivers available to reach OVC. This gives an indication of progression towards this goal.

Inclusions/exclusions: Include only those persons trained to care for OVC and who have completed training as operationally defined by the organization. Do not include individuals trained if it is not related to OVC care.

Strengths and weaknesses: This indicator is useful in that it tracks the number of individuals trained to provide OVC services. The indicator attempts to document increasing capacity to deliver OVC services, however, no conclusion should be drawn regarding the quality of training nor does it measure the outcomes of the training in terms of competencies of the individuals trained or their job performance.

Palliative Care: Basic Health Care and Support and TB/HIV

Program Overview

Palliative care is patient and family centered holistic care and, at its core, addresses a person's mind, body, spirit and societal context, in its approach to HIV care. Under PEPFAR, the palliative approach to HIV care optimizes the quality of life and alleviates the suffering of adults and children living with HIV through the active anticipation, prevention, and treatment of pain, symptoms and suffering from the onset of HIV diagnosis through death. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV and AIDS in order to comprehensively address symptoms and suffering throughout the continuum of illness. The means by which palliative care is achieved will vary according to stage of illness but always with the understanding that improved quality of life and the provision of holistic care involves addressing an HIV-infected individual's or family member's clinical and physical needs, psychological needs, spiritual needs, and social needs.

Given the importance of delivering quality, holistic services for PLWHA, it is ideal for USG South Africa partners to work in collaboration with other partners to encourage and ensure the delivery of comprehensive, family-centered holistic services for PLWHA in all four service delivery categories of clinical/physical care, psychological care, spiritual care and social care. It is anticipated that the combination of services will not only address the care needs of a family but will also build protective measures to address vulnerability and empower family members to potentially protect themselves against HIV. The categories include:

- **Clinical and Physical Care**: Addresses the restoration and maintenance of an HIV-infected individual's immune status and the mitigation of physical consequences related to HIV disease.
- **Psychological Care**: Addresses the non-physical suffering of individuals and family members.
- **Spiritual Care**: Addresses the major life events that cause people to question themselves, their purpose and their meaning in life.
- **Social Care**: Assists individuals and family members in maintaining linkages to and use of care, preventing HIV infection and ensuring adherence to treatment.

Indicators

7.1. Number of service outlets providing HIV-related palliative care (including TB)

Definition: The number of USG-supported service outlets that provide general HIV-related palliative care. Service outlet refers to the lowest level of service that provides HIV-related palliative care for HIV-infected individuals including hospitals, clinics, and mobile units. The minimum requirements for the provision of palliative care are that the service outlet must be able to provide services in at least two categories of clinical, psychological, spiritual or social services. Please refer to the palliative care tables in Appendix B for an illustrative list of palliative care service.

Rationale/what it measures: This indicator measures the expansion of the number of locations that provide HIV-related palliative care services that are delivered in accordance with South African standards. It provides a rough sense of the change in the capacity to provide palliative care services. This will track progress towards the goal of expanding access and coverage of palliative care in South Africa.

Inclusions/exclusions: This indicator includes the total number of service outlets that provide HIV-related palliative care supported by USG. Exclude those not receiving USG resources, including human and

technical resources. Exclude service outlets that do not provide HIV-related services. Also exclude service outlets that do not provide HIV-related services in at least two categories of Palliative Care.

Strengths and weaknesses: This is purely an output measure. This indicator does not describe the geographic location or distribution of service outlets. Although this indicator does attempt to ensure that service outlets can provide a minimum of at least two categories of HIV-related Palliative Care services, this indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.

One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programs monitor which sites provide each of the key interventions: clinical, psychological, spiritual and social.

7.1.A Number of service outlets providing treatment for TB for HIV-infected individuals in a palliative care setting (subset of 7.1)

Definition: The number of service outlets providing treatment for TB for HIV-infected individuals (diagnosed or presumed) according to South Africa standards. This indicator measures the subset of palliative care service outlets that provide specific TB/HIV care. Service outlet refers to those that provide treatment to TB for HIV-infected individuals including hospitals, clinics, and mobile units.

Rationale/what it measures: The co-infection rate of HIV and TB is very high, therefore it is crucial to increase access to TB services. This indicator measures the progress of a programme to expand the number of locations that provide TB treatment for HIV-infected individuals (diagnosed or presumed). It provides a rough sense of the change in the capacity to provide TB and care services. This will track progress towards the goal of expanding access and coverage of palliative care in South Africa.

Inclusions/exclusions: Include USG supported service outlets that provide treatment for tuberculosis to HIV-infected individuals (diagnosed or presumed).

Strengths and weaknesses: This is purely an output measure. This indicator does not describe the geographic location or distribution of service outlets. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.

One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are too difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programmes monitor which sites provide each of the key interventions: medical, psychological, spiritual and social.

7.2. Number of individuals provided with HIV-related palliative care (including TB) (disaggregated by gender)

Definition: The number of HIV-infected (diagnosed or presumed) individuals provided with palliative care services that are directly supported with USG funds (i.e. at the service delivery level). The minimum requirements for someone having received palliative care are that the individual must have received at least one form of clinical care and one other type of non-clinical care. The four categories of Palliative Care

services are clinical, psychological, spiritual or social services. Please refer to the palliative care tables in Appendix B for the list of each type of palliative care service.

Rationale/what it measures: People living with HIV/AIDS should be reached with a comprehensive package of services. Providing only one category of services is not sufficient; PLWHA should be linked or provided with services to meet all of their needs. As a result, at least two categories of services, of which one category must be clinical care services, are required in order for a partner to count that they have delivered HIV-related palliative care services. Clinical care services is a required category in order to address the critical importance of early identification of HIV status and HIV-related clinical problems which may compromise an individual's immune status and physical wellbeing. This indicator is the total number of unduplicated individuals receiving palliative care from USG supported facilities and/or community/home-based organizations. It is the goal of the South African government and PEPFAR to increase access to HIV services in the country. This indicator monitors progress towards this goal.

Inclusions/exclusions: This is not simply the sum of the individuals served by facility-based palliative care (including TB) and community/home-based palliative care partners; adjustment for the overlap in service to the same individuals should be accounted for in this total. Partners should not double count individuals within a program or service outlet, even if the individual accesses services on multiple occasions. An individual will count in separate program areas, such as someone receiving ART, or reached with a prevention program. Individuals receiving non-HIV related services should be excluded. Individuals can be counted in each of the subset categories (see indicators below) if they receive care in the different areas within the reporting period.

Strengths and weaknesses: Adjusting for overlap between programs is very difficult, especially when programs are not well linked and patient confidentiality concerns must be respected. Some overcounting will occur. However, this indicator does not provide any indication of the quality of the services, including how many times PLWHA accessed services nor does it indicate the coverage of a given palliative care programme.

7.2.A Number of HIV-infected individuals that received treatment for TB disease (disaggregated by gender) (subset of 7.2)

Definition: The number of HIV-infected (diagnosed or presumed) individuals who receive treatment for TB disease at service delivery outlets that are directly supported with USG funds. This treatment should be in line with national TB programme treatment guidelines. This data should be reported as a total, and then by number of males reached and number of females reached separately.

Rationale/what it measures: This indicator is the total number of unduplicated individuals receiving treatment for TB from facilities and/or community/home-based organizations. Evidence has shown that previously undiagnosed tuberculosis was detected in a significant proportion (up to 11%) of HIV-infected clients through routine TB screening at HIV counseling and testing services. HIV-infected patients with tuberculosis should be identified and placed on appropriate TB treatment in order to interrupt TB transmission, and reduce the burden of TB among HIV-infected clients. This indicator will measure the implementation of TB and HIV integration and reduce the burden of TB in HIV-infected clients.

Inclusions/exclusions: Only count those who are HIV-infected or presumed HIV-infected and receiving treatment for TB disease.

Strengths and weaknesses: Adjusting for overlap between programmes is very difficult, especially when programmes are not well linked and patient confidentiality concerns must be respected. As TB treatment lasts approximately 6-9 months, this indicator does not measure the outcome of the TB treatment.

7.2 B Number of individuals that received post exposure prophylaxis (subset of 7.2)

Definition: Post Exposure Prophylaxis (PEP) is **short-term** antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure. Antiretroviral therapy should be initiated as soon as possible - within 48 to 72 hours - of sexual, injection-drug use, and other substantial non-occupational HIV exposure and continued for 28 days.

Rationale/what it measures: PEP should be provided to reduce an individual's risk of becoming infected with HIV after exposure to the infection.

Inclusions/exclusions: An individual who receives PEP after exposure to HIV, in any context, should be included in this indicator. An HIV-infected individual given anti-retroviral drugs for the purposes of PMTCT or long-term ART should not be included in this indicator.

Strengths and weaknesses: This indicator demonstrates how many individuals received PEP, which is an important HIV intervention. However, it does not demonstrate how many individuals needed PEP and did not receive it, nor does it demonstrate the efficacy of PEP in preventing HIV infection amongst the recipients of the prophylaxis.

7.2 C Number of HIV-infected individuals that received cotrimoxazole prophylaxis (subset of 7.2)

Definition: The number of HIV-infected individuals who received cotrimoxazole prophylaxis during the reporting period according to the South African Government guidelines.

What it measures: Cotrimoxazole is an important prophylaxis used to prevent Opportunistic Infections to which HIV-infected individuals are at risk. In South Africa, cotrimoxazole prophylaxis is a standard clinical care intervention that should accompany anti-retroviral treatment services. It is vital that PLWHA gain access to cotrimoxazole prophylaxis when it is clinically indicated so they are able to be healthy and productive. This indicator intends to monitor a priority clinical care intervention delivered by providers to HIV-infected individuals needing cotrimoxazole prophylaxis in USG-supported sites. Because success relies on resources and sufficient staff, this indicator also measures commitment to HIV/AIDS care and treatment and in maintaining an uninterrupted supply of cotrimoxazole for prophylactic use.

Inclusions/Exclusions: Only include HIV-infected individuals receiving prophylactic cotrimoxazole. To be included in this indicator, the individual must have received prophylactic cotrimoxazole during the reporting period. Include in this indicator, all individuals on prophylactic cotrimoxazole regardless of whether or not they are on anti-retroviral treatment.

Strengths and weaknesses: This indicator demonstrates the demand for cotrimoxazole prophylaxis at sites supported by USG. This indicator is useful for assessing progress in providing prophylactic cotrimoxazole to individuals with HIV/AIDS. It should be noted that service providers may not be providing appropriate clinical care with prophylactic cotrimoxazole because of a lack of drug availability at sites, lack of appropriate health personnel to prescribe or insufficient access to laboratory monitoring to guide appropriate use of prophylaxis according to South African standards.

This indicator does not capture whether the individual received cotrimoxazole throughout the entire reporting period or for only a short period of time. This indicator is an indication that PLWHA are gaining

access to prophylaxis, however, it does not show the total need. The percentage of PWLHA receiving prophylaxis out of total in need of prophylaxis is not represented in this indicator. This indicator also does not show quality of the clinical care delivered or adherence to cotrimoxazole. One difficulty with this indicator is that prevention of opportunistic infections with prophylaxis and management of opportunistic infections with treatment are often difficult to delineate at service outlets.

7.3 Number of TB patients counseled and HIV tested and received test results (disaggregated by gender)

Definition: The number of individuals who are receiving TB treatment who received HIV pre-test counselling, an HIV test and received their test results with post-test counselling. This data should be reported as a total, and then by number of males reached and number of females reached separately.

Rationale/What it measures: Many individuals who are infected with TB are also infected with HIV. In addition, many individuals do not get HIV counselling and testing until they have advanced HIV disease and arrive at a facility that provides treatment. Testing individuals who have TB for HIV is an opportunity to reach out to many people who may likely be HIV positive. This indicator measures the extent to which people who are infected with TB and receiving TB treatment are then tested for HIV so that they can access HIV care.

Inclusions/Exclusions: Count only persons who are receiving TB treatment and who were counseled, tested and received results for HIV.

Strengths/Weaknesses: This is purely an output measure. This indicator does not consider whether persons identified as being HIV positive are referred for services and actually receive ARV services. There is no dominator of the number of people who are receiving TB treatment to get a measure of the percentage of persons tested for HIV.

7. 4 Number of family members of HIV-infected individuals provided with HIV-related palliative care

Definition: The number of family members of HIV-infected (diagnosed or presumed) individuals provided with palliative care services that are directly supported with USG funds (i.e. at the service delivery level). The minimum requirements for someone having received palliative care are that the individual must have received services in at least two categories of clinical, psychological, spiritual or social services. Please refer to the palliative care tables in Appendix B for an illustrative list of palliative care service.

Family member is defined as a legal spouse or common-law spouse (where legal), same or opposite sex domestic partner, legal guardian, legal ward, son or daughter (adopted*, foster*, step or in-law), brother or sister (adopted*, foster*, step or in-law), parent (includes step or in-law), grandparent (includes in-law), great-grandparent (includes in-law), grandchild, great-grandchild, aunt, uncle, niece, nephew, cousin or member of household of an HIV-infected individual that may or may not live in the same residence**.

**Adopted and foster relationships may include both legal and informal arrangements.*

***In the context of palliative care in Africa, home or household does not mean physical infrastructure in which a person lives, but also involves the biological, sociological and spiritual roots of an individual.*

Rationale/what it measures: Fundamental to the palliative approach to HIV care is actively engaging and supporting family members of PLWHA. Family members of PLWHA should be reached with a comprehensive package of services. Providing only one category of services is not sufficient, but families

should be linked or provided with services to meet all their needs. As a result, at least two categories of services are required for a partner to count that they have delivered HIV-related palliative care services to family members of HIV-infected (diagnosed or presumed) individuals. This indicator is the total number of unduplicated family members of HIV-infected individuals, receiving care from USG supported facilities and/or community/home-based organizations. It is the goal of the South African government and PEPFAR to increase access of HIV services in the country. This indicator monitors progress towards this goal.

Inclusions/exclusions: Family members of HIV-infected individuals should be included if they received HIV-related palliative care in at least two categories of palliative care (listed in appendix B). Partners should not double count individuals within a program or service outlet, even if the individual accesses services on multiple occasions. Individuals receiving non-HIV related services should be excluded.

Family members who are infected with HIV and receiving HIV-related palliative care services should be excluded here and counted in indicator "Number of individuals provided with HIV-related palliative care (including TB) (disaggregated by gender)". If applicable, the HIV-infected family member may also be counted in the ARV Services Program Area.

Strengths and weaknesses: Adjusting for overlap between programs is very difficult, especially when programs are not well linked and patient confidentiality concerns must be respected. Some overcounting may occur. This indicator measures the change in reach of comprehensive palliative care programs. However, this indicator does not provide any indication of the quality of the services, including how many times PLWHA accessed services nor does it indicate the coverage of a given palliative care programme.

7.5 Number of TB cases*

** This indicator is required for all USAID supported TB programmes and optional for other USG supported programmes.*

Definition: The total number of TB cases diagnosed.

Rationale/what it measures: This indicator provides information on the number of TB cases detected. Because effective treatment of TB patients reduces TB transmission, early detection is one of the main strategies of TB control, and the indicator measures the programme's capacity to identify those sources. Information on true incidence or prevalence of TB disease is unlikely to be available. Trends over time in case notification usually indicate changes in programme coverage and capacity to detect TB cases; at high levels of case detection, the indicator reflects changes in the prevalence of TB in the community. Additionally, it provides data for programme planning and M&E purposes, and it should be used as a measure to guide these activities. For example, an upward trend in case notification rates can reflect an improvement in programme performance or, in some cases, the impact of the HIV/AIDS epidemic.

Inclusions/exclusions: Only count those who are diagnosed with TB.

Strengths and weaknesses: This indicator only captures number of TB cases reported.

7.6 Number of Pulmonary TB*

** This indicator is required for all USAID supported programmes and optional for other USG supported programmes.*

Definition: As a subset of the total number of TB cases diagnosed, report the number of pulmonary TB cases.

Rationale/what it measures: Pulmonary TB is likely to be more infectious than non-pulmonary forms of TB that needs to be tracked separately. Also, it is important to track over time to see if there is an increase/decrease in case detection.

Inclusions/exclusions: Only count those diagnosed with pulmonary TB. Exclude other forms of TB.

Strengths and weaknesses: This indicator only captures number of TB cases reported. It also does not give geographic coverage.

7.7 Number of new smear positives*

** This indicator is required for all USAID supported programmes and optional for other USG supported programmes.*

Definition: The total number of individual TB cases reported as new smear positive pulmonary cases.

Rationale/what it measures: The indicator assesses the adequacy of smear diagnosis for TB suspects, specifically the utilization of laboratory services by diagnosing clinicians for determining whether or not a TB suspect has infectious TB. It reflects the development of programme screening of TB suspects with sputum smear microscopy, as well as the relative weight of medical diagnosis of pulmonary TB without microscopy examination or with negative smears. In programme conditions in countries with medium or high TB burden, over two-thirds of pulmonary TB in adults should present with positive smears (the remainder being either culture-positive or culture-negative pulmonary TB). The proportion of children with smear positive pulmonary TB is quite low. Although the diagnosis of TB can be made in smear negative individuals (particularly in children and those who had never been treated), the absence of bacteriological examination is not an acceptable medical practice in the diagnosis of pulmonary TB in adults. Under programme conditions, when microscopy laboratory services are available and diagnostic criteria are properly applied, pulmonary TB smear positive cases represent at least 65% of the total pulmonary TB cases in adults and 50% or more of all TB cases. These proportions may be lower in populations with high HIV incidence.

Inclusions/exclusions: Only count those who were smear positive for TB. Exclude other forms of diagnosed TB cases.

Strengths and weaknesses: The indicator is a direct measure of programme capacity to identify infectious cases. The number of new pulmonary smear positive TB cases provides a better comparison and trends over time between areas, as compared with the number of total cases, because it uses a single, objective method (sputum microscopy). However, case notification represents only a subset of the true number of cases arising in a country because of incomplete coverage by health services or deficient recording and reporting. Although case notifications under-represent the true burden of disease, they often represent the most useful data for estimating incidence.

7.8 Number of successfully treated TB*

** This indicator is required for all USAID supported programmes and optional for other USG supported programmes.*

Definition: Successful treatment rates include the number of individuals provided treatment for TB who were either cured of TB plus those who completed TB treatment. Cured is defined as those individuals who were initially sputum smear positive for TB, were treated with a complete course of TB treatment, tested smear negative at or one month prior to completion and on at least one previous occasion. Completed TB treatment count includes those who initially tested smear positive, completed a full course of TB treatment and do not have any documentation of a subsequent negative TB smear or those with no smear examined at diagnosis or those who were initially diagnosed with extra-pulmonary TB and completed a full course of TB treatment.

Rationale/what it measures: Evidence has shown that previously undiagnosed tuberculosis was detected in a significant proportion (up to 11%) of HIV-infected clients through routine TB screening at HIV counseling and testing services. HIV-infected patients with tuberculosis should be identified and placed on appropriate TB treatment in order to interrupt TB transmission, and reduce the burden of TB among HIV-infected clients. This indicator measures the success rate of TB treatment programmes in reducing the burden of TB in HIV-infected clients.

Inclusions/exclusions: Only count those who completed treatment for TB at a USG supported site.

Strengths and weaknesses: One important limitation is that success (and other treatment outcomes monitored routinely in TB programmes) is an outcome of treatment regimens, not patient results. Although it might be useful to analyze a cohort of TB patients in terms of survival or TB-free status at a given point in time -- after say, 12 or 24 months -- the routine TB monitoring system was not designed to facilitate such an analysis. In the routine TB monitoring system, an outcome is an irrevocable event (or status assignment) that signals an end of the current treatment regimen. An end is declared because the regimen was completed (cured, completed), because the regimen is no longer applicable (failure, default), or because no information could be obtained (death, transfer out, and not evaluated). Obviously, some cases with recorded outcomes of failure or default may go on to be cured (after re-registration for re-treatment regimens), and some cured cases may go on to relapse. Some default cases are never seen again and may therefore have died or spontaneously healed or found treatment elsewhere. The only status assignment serving both types of analysis (routine monitoring versus survival analysis) is death. Where there is interest in monitoring outcomes of patients (as distinct from outcomes of regimens), more sophisticated relational linkages must be introduced into the record-keeping system.

7.9 Number of HIV-infected individuals in a palliative care program that were referred for ART

Definition: The number of HIV infected individuals receiving palliative care at a USG supported service outlet that were referred to a treatment programme. A treatment programme includes the provision of antiretroviral drugs and clinical monitoring.

Rationale/what it measures: Once diagnosed as HIV-infected, individuals may need to be referred for treatment services. Palliative care is an entry point for treatment and the goal is to increase access to treatment for those in need. This indicator provides an estimate of the number of individuals who are currently receiving palliative care services who are referred on to treatment services.

Inclusions/exclusions: Count only HIV infected individuals receiving palliative care at a USG supported site who were referred to a treatment programme. Exclude HIV infected individuals already enrolled in a treatment programme.

Strengths and weaknesses: This indicator only counts those who are referred and does not assess whether the individuals actually received the services. This indicator is biased, as the individual has already presented for palliative care services.

7.10 Number of individuals provided with HIV-related palliative care (including TB) (indirect)

Definition: The number of HIV-infected (diagnosed or presumed) individuals receiving palliative care services that were indirectly supported with USG funding. Indirect support includes any of the following activities: national, provincial, or district level policy development; institutional capacity building; logistics; protocol or guideline development; advocacy; national, provincial, district level training; and national, provincial, or district level management information systems. See page 25 for further information.

Rationale/what it measures: There are a number of support functions that are essential for the provision of quality palliative care services. This indicator tries to quantify the indirect inputs that USG partners make to this process by estimating the number of individuals who received palliative care services indirectly.

Inclusions/exclusions: Only include the estimated number of HIV infected individuals who received palliative care services. Individuals must be presumed or diagnosed HIV positive.

Strengths and weaknesses: There may be some facilities that receive both direct and indirect support. Indirect support is an estimate and not actual reported data.

7.10A Number of HIV-infected individuals who received treatment for TB disease (subset of 7.9) (indirect)

Definition: The number of HIV-infected (diagnosed or presumed) individuals who received treatment for TB that were indirectly supported with USG funding. This is a subset of 7.9. Indirect support includes any of the following activities: national, provincial, or district level policy development; institutional capacity building; logistics; protocol or guideline development; advocacy; national, provincial, district level training; and national, provincial, or district level management information systems.

Rationale/what it measures: There are a number of support functions that are essential for the provision of quality TB care services. This indicator tries to quantify the indirect inputs that USG partners make to this process by estimating the number of individuals who received treatment for TB disease indirectly.

Inclusions/exclusions: Only include the estimated number of HIV infected individuals who received treatment for TB disease. Individuals must be presumed or diagnosed HIV positive.

Strengths and weaknesses: There may be some facilities that receive both direct and indirect support. Indirect support is an estimate and not actual reported data.

7.11 Number of individuals trained to provide HIV-related palliative care (including TB/HIV)

Definition: The number of individuals trained to provide HIV-related palliative care for HIV-infected individuals (diagnosed or presumed) and includes those trained in facility-based, community-based and/or home-based care, including TB/HIV.

Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when these exist. A training must have specific learning

objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants. Training on HIV-related palliative care services may include: a) clinical/medical including TB/HIV b) psychological, c) spiritual, and/or d) support care services for HIV-infected individuals and family members.

Rationale/what it measures: This indicator is a measure of health providers who have been trained in general HIV-related palliative care for HIV-infected individuals. It is an indication of the expansion of health care workers who are available to provide care.

In many countries, the national AIDS coordination body and/or professional organizations have defined training standards. This applies in particular to countries that have introduced certification systems for HIV/AIDS training. The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programmes in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: This indicator is the total number of individuals receiving training for palliative care (including those trained in TB/HIV). Only participants who complete the full training course should be counted. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Strengths and weaknesses: This indicator is useful in that it tracks the number of health care providers trained to provide palliative care to HIV-infected individuals. The indicator attempts to document increasing capacity to deliver palliative care to HIV-infected individuals. This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

7.11A Number of individuals trained to provide treatment for TB to HIV-infected individuals (subset of 7.11)

Definition: The number of individuals trained to provide treatment for TB to HIV-infected individuals (diagnosed or presumed) and includes those trained in facility-based, community-based and/or home-based care. Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when they exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

Rationale/what it measures: This indicator is a measure of health care providers who have been trained in the delivery of treatment for TB to HIV-infected individuals. It measures the number of newly trained or retrained individuals who are able to deliver treatment for TB to HIV-infected individuals. This is a subset of the total number trained for HIV-related palliative care that had specific training on TB/HIV.

In many countries, the national AIDS coordination body and/or professional organizations have defined training standards. This applies in particular to countries that have introduced certification systems for HIV/AIDS training. The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programmes in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: This indicator is the number of individuals trained to provide treatment for TB to HIV-infected individuals. Only participants who complete the full training course should be counted. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Strengths and weaknesses: This indicator is useful in that it tracks the number of health care providers trained to provide treatment for TB to HIV-infected individuals. The indicator attempts to document increasing capacity to deliver treatment for TB to HIV-infected individuals. However, no conclusion should be drawn regarding the quality of training nor does it measure the outcomes of the training in terms of competencies of the individuals trained or their job performance.

7.12 Number of hours technical assistance provided in HIV-related health care and support

Definition: The number of person hours of technical assistance provided by the PEPFAR-supported partner to local NGOs, national or provincial Departments of Health, or other institutions for building capacity to provide basic health care and support services.

Technical assistance (TA) is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of programmes in the specified area. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Rationale/what it measures: Technical assistance is one strategy along with training and mentoring that may increase the capacity of organizations to provide basic health care and support for HIV-infected and affected populations. This indicator measures the amount of technical assistance provided by USG supported technical experts in the area of basic health care and support to governmental and non-governmental partners. It reflects capacity building efforts to improve programmes and develop policies in this area.
Inclusions/exclusions: Include person hours of technical assistance provided specifically for strengthening HIV related palliative care or TB/HIV programmes and/or policies.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator attempts to capture an input into a process, but does not indicate the quality of the technical assistance provided or if the intended output was achieved.

7.13 Number of hours technical assistance provided for strengthening TB/HIV services

Definition: The number of person hours of technical assistance provided by the PEPFAR-supported partner to local NGOs, national or provincial Departments of Health, or other institutions for building capacity to strengthen TB/HIV services.

Technical assistance (TA) is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of programmes in the specified area. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships,

national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Rationale/what it measures: Technical assistance is one strategy, along with training and mentoring, that may increase the capacity of organizations to provide TB/HIV services for HIV-infected individuals. This indicator measures the amount of technical assistance provided by USG technical experts in the area of TB/HIV services to governmental and non-governmental partners. It reflects capacity building efforts to improve programmes and develop policies in this area.

Inclusions/exclusions: Include person hours of technical assistance provided specifically for strengthening TB/HIV programmes and/or policies.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator attempts to capture an input into a process, but does not indicate the quality of the technical assistance provided or if the intended output was achieved.

Antiretroviral Treatment Services

Programme Overview

With more than 6 million South Africans infected with HIV, the need to address the medical, social and psychosocial demands in the public and private sector is ever-increasing. A continuum of care, that includes treatment, would be focused on ensuring that people know their status (through HIV counseling and testing), have their opportunistic infections managed (e.g. through a wellness program), and are assessed for eligibility for ARV treatment in a timely fashion (e.g. as part of HIV counseling and testing).

HIV/AIDS treatment services include the provision of antiretroviral (ARV) drugs and clinical monitoring for antiretroviral treatment (ART) among those with advanced HIV infection. The number of clients on ART has subsets of new clients and continuous clients. These are calculated based on the date at the end of the reporting period (i.e., March 31 or September 30).

Definitions commonly used in this section:

Antiretroviral therapy: Long-term combination antiretroviral therapy intended primarily to improve the health of the individual on treatment, not to prevent mother-to-child transmission.

ART services: Activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection.

Pregnant: A current client is pregnant if she was pregnant at any time during the reporting period, regardless of the outcome of the pregnancy.

Sex: Refers to male or female.

Age: Age is divided into three categories: 0-5, <15, and >= 15 years. Some facilities collect either 0-4 or 0-5. Either one can be reported under the 0-5 column. Please note it in your report if you are reporting 0-4 instead of 0-5.

At the end of the reporting period: The last day of the 6-month or 12-month reporting period.

This section is divided into two parts: (1) direct treatment services and (2) activities in support of treatment. The indicators listed in direct treatment services are collected on a separate template by site on a quarterly basis. The data reported should reflect the program activities at that site and related feeder clinics during the reporting period.

Indicators: Direct Treatment Services

8.1A Number of service outlets providing HIV counseling and testing

Definition: A service outlet refers to the lowest level of service - where the testing actually occurs. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a health centre, hospital, clinic, stand alone CT centre, or mobile unit. This indicator excludes service outlets that provide counselling and testing in the context of preventing mother-to-child transmission. Please refer to indicator 4.1 in the SASI manual for more guidance on reporting the number of service outlets that provide services to prevent mother-to-child transmission of HIV.

Rationale/What it measures: This indicator provides a gross count of the number of USG supported locations that provide basic counselling and testing for HIV. It provides a rough sense of coverage of counselling and testing services. If there is a plan to expand the number of service outlets, this measure will track the progress of meeting that goal.

Inclusions/Exclusions: Counseling and testing for PMTCT should be included in the PMTCT programme area only.

Strengths/Weaknesses: This is purely an output measure. It provides no sense of the geographical spread of CT services, nor any relationship to the percentage of the population that is reached by the service outlet. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.

8.1B Number of service outlets providing HIV-related palliative care (including TB)

Definition: The number of USG-supported service outlets that provide general HIV-related palliative care. Service outlet refers to the lowest level of service that provides HIV-related palliative care for HIV-infected individuals including hospitals, clinics, and mobile units. The minimum requirements for the provision of palliative care are that the service outlet must be able to provide services in at least two categories of clinical, psychological, spiritual or social services. Please refer to the palliative care tables in Appendix B for an illustrative list of palliative care service.

Rationale/what it measures: This indicator measures the progress of a program to expand the number of locations that provide HIV-related palliative care services that are delivered in accordance with South African standards. It provides a rough sense of the change in the capacity to provide palliative care services. This will track progress towards the goal of expanding access and coverage of palliative care in South

Inclusions/exclusions: This indicator includes the total number of service outlets that provide HIV-related palliative care supported by USG. Exclude those not receiving USG resources, including human and technical resources. Exclude service outlets that do not provide HIV-related services. Also exclude service outlets that do not provide HIV-related services in at least two categories of Palliative Care.

Strengths and weaknesses: This is purely an output measure. This indicator does not describe the geographic location or distribution of service outlets. Although this indicator does attempt to ensure that service outlets can provide a minimum of at least two categories of HIV-related Palliative Care services, this indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.

One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programs monitor which sites provide each of the key interventions: clinical, psychological, spiritual and social.

8.1C Number of service outlets providing treatment for TB (subset of palliative care outlets)

Definition: The number of service outlets providing treatment for TB for HIV infected individuals (diagnosed or presumed) according to South African standards. This indicator measures the subset of palliative care service outlets that provide specific TB/HIV care. Service outlet refers to the lowest level of

service that provides treatment to TB for HIV-infected individuals including hospitals, clinics, and mobile units.

Rationale/What it measures: The co-infection rate of HIV and TB is very high, therefore it is crucial to increase access to TB services. This indicator measures the progress of a programme to expand the number of locations that provide treatment for TB for HIV-infected individuals (diagnosed or presumed) services that are delivered in accordance with South African standards. It provides a rough sense of the change in the capacity to provide TB and care services. This will track progress towards the goal of expanding access and coverage of palliative care in South Africa.

Inclusions/Exclusions: A USG supported service outlet that will count in this indicator will provide treatment for tuberculosis to HIV-infected individuals (diagnosed or presumed).

Strengths/Weaknesses: This is purely an output measure. This indicator does not describe the geographic location or distribution of service outlets. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.

One difficulty with this indicator is that while facility-based or community-based service outlets in fixed locations are relatively straight-forward to measure, community-based or home-based outreach activities are too difficult to define as service outlets and are not captured in this indicator. It is recommended that at country level, programmes monitor which sites provide each of the key interventions: medical, psychological, spiritual and social.

8.1D Number of service outlets providing antiretroviral treatment

Definition: The number of service outlets that provide ART. A service outlet refers to the lowest level of service delivery providing ART including hospitals, clinics, and mobile units. ART services are activities including the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection. South African or international standards refer to national guidelines and policies to promote ART training and services in a comprehensive way, linking them with HIV prevention and care and with the strengthening of health systems. National guidelines and policies are often based on existing international guidelines, and are generally agreed upon in a national forum. Without standards, services of unknown quality and impact can be implemented on an ad hoc basis, making it difficult to monitor and evaluate efforts.

Rationale/what it measures: This indicator measures the progress of a programme to expand the number of locations in which ART services are delivered in accordance with South African or international standards. It provides a rough sense of the change in the capacity within a country to provide ART services. If there is a plan to expand the number of service outlets, this measure will track the progress of meeting that goal.

Inclusions/exclusions: Include only those service outlets that are supported with USG funding at the service delivery level.

Strengths and weaknesses: This is purely an output measure. This indicator does not describe the geographic location or distribution of service outlets. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.

8.2 Number of individuals counseled and HIV tested and received test results (disaggregated by gender)

Definition: The number of individuals who received pre-test counselling, an HIV test and received their test results with post-test counselling at an ART facility during the quarter. "Treatment facility" refers to all levels of service that provide ART including hospitals, clinics, and mobile units. This data should be reported as a total, and then by number of males reached and number of females reached separately.

Rationale/What it measures: Many individuals do not get HIV counselling and testing until they have advanced HIV disease and arrive at a facility that provides treatment. This indicator provides a count of the individuals who have been counselled and tested in treatment facilities.

Inclusions/Exclusions: Count only those who are counselled and tested in treatment facilities.

Strengths/Weaknesses: This is purely an output measure. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total individuals seen at treatment sites.

8.2A Number of TB patients counseled and HIV tested and received test results (disaggregated by gender) (subset of 8.2)

Definition: The number of individuals who are receiving TB treatment who received HIV pre-test counselling, an HIV test and received their test results with post-test counselling. This data should be reported as a total, and then by number of males reached and number of females reached separately.

Rationale/What it measures: Many individuals who are infected with TB are also infected with HIV. In addition, many individuals do not get HIV counselling and testing until they have advanced HIV disease and arrive at a facility that provides treatment. Testing individuals who have TB for HIV is an opportunity to reach out to many people who may likely be HIV positive. This indicator measures the extent to which people who are infected with TB and receiving TB treatment are then tested for HIV so that they can access HIV care.

Inclusions/Exclusions: Count only persons who are receiving TB treatment and who were counseled, tested and received results for HIV.

Strengths/Weaknesses: This is purely an output measure. This indicator does not consider whether persons identified as being HIV positive are referred for services and actually receive ARV services. There is no dominator of the number of people who are receiving TB treatment to get a measure of the percentage of persons tested for HIV.

8.3 Number of HIV-infected individuals who received pre-treatment training

Definition: The number of HIV-infected individuals who received pre-treatment training during the quarter. Report this indicator by individuals, not by sessions. Pre-treatment training may vary by facility, but must include adherence counselling and ART literacy.

Rationale/What it measures: Pre-treatment training is essential to the success of ART programmes and on health outcomes for the individual. This indicator is a measure of the number of HIV-infected individuals who have completed pre-treatment training prior to initiating treatment.

Inclusions/Exclusions: Only individuals who complete pre-treatment training as defined by the facility should be included.

Strengths/Weaknesses: This indicator is useful in that it tracks the number of people who received pre-treatment training and level of effort of the ART programme in preparing people for ART. However, since it is purely an output measure, it does not measure the effectiveness of the pre-treatment training.

8.4 Number of HIV-infected individuals who received ARV adherence counselling

Definition: The number of HIV-infected individuals who received adherence counselling training during the quarter. Report this indicator by individuals, not by sessions.

Rationale/What it measures: Adherence is essential to the success of ART programmes. This indicator is a measure of the number of HIV-infected individuals who receive adherence counselling prior to initiating or to reinforce the importance of adherence after already initiating treatment.

Inclusions/Exclusions: Include all individuals who received any adherence counselling during the quarter.

Strengths/Weaknesses: This indicator is useful in that it tracks the number of people counselled in adherence. However, since it is purely an output measure, it does not track patient health outcomes as a result of the adherence counselling.

Palliative Care Guidance for indicators 8.5 – 8.8

Note that this is not an indicator but provides guidance for palliative care for indicators 8.5-8.8.

Definition: The number of HIV-infected (diagnosed or presumed) individuals provided with palliative care services that are directly supported with USG funds (i.e. at the service delivery level). The minimum requirements for someone having received palliative care are that the individual must have received at least one form of clinical care and one other type of non-clinical care. The four categories of Palliative Care services are clinical, psychological, spiritual or social services. Please refer to the palliative care tables in Appendix B for the list of each type of palliative care service.

Rationale/what it measures: People living with HIV/AIDS should be reached with a comprehensive package of services. Providing only one category of services is not sufficient; PLWHA should be linked or provided with services to meet all their HIV-related needs. As a result, at least two categories of services, of which one category must be clinical care services, are required for a partner to count that they have delivered HIV-related palliative care services. Clinical care services is a required category in order to address the critical importance of early identification of HIV status and HIV-related clinical problems which may compromise an individual's immune status and physical wellbeing. This indicator is the total number of unduplicated individuals receiving palliative care from USG supported facilities and/or community/home-based organizations. It is the goal of the South African government and PEPFAR to increase access to HIV services in the country. This indicator monitors progress towards this goal.

Inclusions/exclusions: This is not simply the sum of the individuals served by facility-based palliative care (including TB) and community/home-based palliative care partners; adjustment for the overlap in service to the same individuals should be accounted for in this total. Partners should not double count individuals within a program or service outlet, even if the individual accesses services on multiple occasions. An individual will count in separate program areas, such as someone receiving ART, or reached with a prevention program. Individuals receiving non-HIV related services should be excluded. Individuals can be counted in each of the subset categories (see indicators below) if they receive care in the different areas within the reporting period.

Strengths and weaknesses: Adjusting for overlap between programs is very difficult, especially when programs are not well linked and patient confidentiality concerns must be respected. Some overcounting will occur. This indicator measures the change in reach of comprehensive palliative care programs. However, this indicator does not provide any indication of the quality of the services, including how many times PLWHA accessed services nor does it indicate the coverage of a given palliative care programme.

8.5 Cumulative number enrolled in HIV care by the beginning of quarter (disaggregated by age, gender and pregnancy status)

Definition: The cumulative number of HIV-infected individuals enrolled in a care or wellness programme by the first day of the quarter since the beginning PEPFAR support at the facility. Include those on ART as well as those not yet initiated on ART for any reason like having a CD4 count above 200 or having TB, since it is assumed that those on ART are also receiving some form of HIV care or monitoring in addition to receiving ARV drugs. This indicator is intended to capture all those who have ever been enrolled in care and therefore includes those who are also no longer in care including those who have died or are lost to follow-up. This data should be disaggregated by age (0-5 years, 0-14 years and 15 and over) and gender (male and female).

Rationale/What it measures: This indicator provides a total count of individuals who have received any type of HIV care by the beginning of the quarter, regardless of whether they are still receiving care. This number provides a baseline against which to measure new enrollees during the quarter.

Inclusions/Exclusions: Count all individuals who were enrolled in any type of HIV care at the beginning the reporting period.

Strengths/Weaknesses: This is purely an output measure. It intends to capture the number of people who were ever enrolled in HIV care at the facility.

8.6 New enrollees in HIV care during the quarter (disaggregated by age, gender)

Definition: The number of HIV-infected individuals newly enrolled in HIV care during the quarter. Include those on ART and those individuals who have not yet initiated ART for any reason like having a CD4 count above 200 or having TB, since it is assumed that those on ART are also receiving some form of HIV care or monitoring in addition to receiving ARV drugs. This indicator should be disaggregated by sex and age and should be referred to as new clients. This data should be is aggregated by age (0-5 years, 0-14 years and 15 and over) and gender (male and female).

Rationale/What it measures: This indicator provides a count of individuals who are newly enrolled in HIV care.

Inclusions/Exclusions: Exclude those enrolled in care before the beginning of the quarter. Count those on ART as well as those not yet initiated on ART.

Strengths/Weaknesses: This is purely an output measure. This indicator does not consider the quality of service provision. By tracking this indicator over time, it shows the uptake ART services at the facility.

8.7 Cumulative number enrolled in HIV care by the end of the quarter (disaggregated by age, gender)

Definition: This column automatically sums the 'cumulative number enrolled in HIV care by the beginning of the quarter' with the 'new enrollees in HIV care during the quarter'. It captures the cumulative number ever enrolled in HIV care by the end of the quarter and includes both those who have received care and may or may not be eligible for ART and those that have died or are lost to follow-up. This data should be disaggregated by age (0-5 years, 0-14 years and 15 and over) and gender (male and female).

Rationale/What it measures: This indicator provides a total count of individuals who have received any type of HIV care by the end of the quarter since the beginning of the quarter, regardless of whether they are still receiving care.

Inclusions/Exclusions: Include all individuals who received care since the beginning of the programme. Count those on ART as well as those not yet initiated on ART.

Strengths/Weaknesses: This is purely an output measure. This indicator does not consider the quality of service provision.

8.8 Number who received HIV care during the reporting period (disaggregated by age, gender)

Definition: This indicator captures the number of HIV-infected individuals who received care at any time within the reporting period. This indicator is captured for the quarterly, semi-annual and annual reporting periods. For the purpose of this indicator, care is defined as any encounter between a staff person and the person in care including enrolment visits, medical visits, home-based/community-based care, laboratory visits, visits to the pharmacy or adherence counselling. Only report the number of individuals, not the number of visits. If a patient dies in the second month, but received care in month one, they are still reported here, as they received care at some point in the reporting period. This data should be disaggregated by age (0-5 years, 0-14 years and 15 and over) and gender (male and female).

Rationale/What it measures: This indicator provides a count of individuals who received HIV care during the reporting period including new enrollees and former patients.

Inclusions/Exclusions: Count those on ART as well as those not yet initiated on ART.

Strengths/Weaknesses: This is purely an output measure that shows the service uptake at the facility during the quarter. This indicator does not consider the quality of service provision.

8.9 Number in HIV care during the quarter & eligible for ART, but NOT started ART by the end of the quarter

Definition: The number of HIV-infected individuals who met the facility's definition of being eligible for ART, but who had not started on ART by the end of the quarter.

Rationale/What it measures: This indicator provides a count of individuals who meet a facility's definition of being eligible for ART, but who have not yet started ART. This indicator measures the unmet need for ART at the facility.

Inclusions/Exclusions: Only include those not yet on ART, but who meet the eligibility criteria at the facility.

Strengths/Weaknesses: This indicator aims to measure the 'waitlist' for individuals eligible for ART but not able to start treatment for a variety of reasons, especially resource constraints at the facility.

8.10 Number in HIV care that are receiving treatment for TB disease (disaggregated gender)

Definition: The number of HIV-infected persons who are receiving treatment for TB (subset of the total number who palliative care). Please report on this indicator for each of the columns, i.e. both the quarter and the year. This data should be reported as a total, and then separately by number of males reached and number of females reached. Note that this indicator is also captured for the semi-annual and annual reporting periods.

Rationale/what it measures: This indicator provides a count of individuals who received treatment for TB during the quarter and during the year, including new enrollees and former patients.

Inclusions/exclusions: Include only HIV-infected individuals who received treatment for TB during the reporting period.

Strengths and weaknesses: This is purely an output measure. This indicator does not consider the quality of service provision. It attempts to track the integration of TB/HIV services.

8.11 Number of HIV-infected individuals receiving cotrimoxazole prophylaxis

Definition: The number of HIV-infected individuals who received cotrimoxazole prophylaxis during the reporting period according to the South African Government guidelines.

What it measures: Cotrimoxazole is an important prophylaxis used to prevent Opportunistic Infections to which HIV-infected individuals are at risk. In South Africa, cotrimoxazole prophylaxis is a standard clinical care intervention that should accompany anti-retroviral treatment services. It is vital that PLWHA gain access to cotrimoxazole prophylaxis when it is clinically indicated so they are able to be healthy and productive. This indicator intends to monitor a priority clinical care intervention delivered by providers to HIV-infected individuals needing cotrimoxazole prophylaxis in USG-supported sites. Because success relies on resources and sufficient staff, this indicator also measures commitment to HIV and AIDS care and treatment and in maintaining an uninterrupted supply of cotrimoxazole for prophylactic use.

Inclusions/Exclusions: Only include HIV-infected individuals receiving prophylactic cotrimoxazole. To be included in this indicator, the individual must have received prophylactic cotrimoxazole during the reporting period. Include in this indicator, all individuals on prophylactic cotrimoxazole regardless of whether or not they are on anti-retroviral treatment.

Strengths and weaknesses: This indicator demonstrates the demand for cotrimoxazole prophylaxis at sites supported by USG. This indicator is useful for assessing progress in providing prophylactic cotrimoxazole to individuals with HIV/AIDS. It should be noted that service providers may not be providing appropriate clinical care with prophylactic cotrimoxazole because of a lack of drug availability at sites, lack of appropriate health personnel to prescribe or insufficient access to laboratory monitoring to guide appropriate use of prophylaxis according to South African standards.

This indicator does not capture whether the individual received cotrimoxazole throughout the entire reporting period or for only a short period of time. This indicator is an indication that PLWHA are gaining access to prophylaxis, however, it does not show the total need. The percentage of PWLHA receiving prophylaxis out of total in need of prophylaxis is not represented in this indicator. This indicator also does

not show quality of the clinical care delivered or adherence to cotrimoxazole. One difficulty with this indicator is that prevention of opportunistic infections with prophylaxis and management of opportunistic infections with treatment are often difficult to delineate at service outlets.

8.12 Cumulative number started on ART by the beginning of the quarter (disaggregated by age, gender and pregnancy status)

Definition: The cumulative number of HIV-infected individuals who had started on ART by the first day of the quarter since the facility started receiving PEPFAR funding. This data should be disaggregated by age (0-5 years, 0-14 years and 15 and over), gender (male and female) and pregnancy status (at the time of enrolment). Disaggregation of pregnant women by age is not required.

Rationale/What it measures: This indicator is intended to capture all those who had ever started on ART and therefore includes those who are also no longer receiving ART. This includes those who have died or are lost to follow-up.

Inclusions/Exclusions: Include all patients at the facility who ever received ART since the facility started receiving PEPFAR funding regardless of whether or not they are still receiving ART or the funding source of the ART drugs.

Strengths/Weaknesses: This is purely an output measure. It intends to capture the number of people who were ever enrolled in ART at the facility.

8.12 Number new on ART during the quarter (disaggregated by age, gender and pregnancy status)

Definition: The number of HIV-infected individuals who newly started on ART during the quarter at PEPFAR supported facilities. Include all patients at the facility regardless of the funding source of the ARV drugs. New patients do not have to be treatment naïve.

For example, if a woman previously received Nevirapine for PMTCT she would not be treatment naïve. *Newly initiated* refers to newly initiated antiretroviral therapy during the reporting period in a programme directly supported by USG funds.

This data should be disaggregated by age (0-5 years, 0-14 years and 15 and over), gender (male and female) and pregnancy status (at the time of enrolment). Age represents an individual's age at initiation of therapy. The number of pregnant women is to be shown as a subset of all new women on ART.

Rationale/What it measures: There are three programme indicators that count individuals receiving antiretroviral therapy at a service outlet directly supported by PEPFAR funds: new, cumulative, and current. This particular indicator provides a count of individuals newly initiated on antiretroviral therapy during a reporting period.

Inclusions/Exclusions: If an individual transfers in to the ART programme with records of continuous ART from another facility or programme, this person should not be counted as new. If an individual transfers in without records or has no documented evidence of previous antiretroviral therapy, this person may be counted as new because programmes have no choice but to enroll this person as a new client. If an individual previously on ART in the programme restarts ART after an interruption in therapy, this person should not be counted as new.

If an individual initiated treatment during the period but died, stopped ART, or transferred out before the

end of the reporting period, this person should still be counted as new since status at the end of the period does not affect the fact that the person was still new on therapy during the period.

Strengths/Weaknesses: As the health of ART clients improve and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one programme/facility over time. At the country level, these clients will be double counted in the NEW and CUMULATIVE client indicators. Double counting of individuals within a programme area is to be avoided to the extent possible.

Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. Because "new" and "cumulative" are states defined at the start of a programme, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a programme. On the contrary, "current" is a state defined by vital/treatment status at last visit so it is expected that characteristics of these clients would be updated each time they are seen by a programme. Combining all children into one age group of < 15 yrs may not be satisfactory for programme managers. There are different criteria for starting treatment, as well as different disease burdens, care needs, and mortality patterns for children of different ages. Programmes may wish to further disaggregate children by age to follow programmatically and clinically meaningful differences as follows: 0-18 months, 18 months-5 years, and 6-14 years.

8.13 Number on ART who transferred in during the quarter (disaggregated by age, gender and pregnancy status)

Definition: The number of HIV-infected individuals already on ART who transferred to the PEPFAR programme at the facility during the quarter. Include all patients at the facility regardless of the actual funding source of the ARV drugs. This data should be disaggregated by age (0-5 years, 0-14 years and 15 and over), gender (male and female) and pregnancy status (at the time of enrolment). Disaggregation of pregnant women by age is not required.

Rationale/What it measures: It is important to keep track of patients on ART as they move from one facility to another. This indicator measures the level of movement between facilities.

Inclusions/Exclusions: If an individual transfers in to the ART programme with records from continuous ART at another facility or programme, this person should be counted as transferred. If an individual transfers in without records or has no documented evidence of previous antiretroviral therapy, this person may be counted as new because programmes have no choice but to enroll this person as a new client.

Strengths/Weaknesses: As the health of ART clients improves and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one programme/facility over time. At the country level, these clients will be double counted in the NEW and CUMULATIVE client indicators. Double counting of individuals within a programme area is to be avoided to the extent possible.

8.14 Number started on ART programme during the quarter (includes new and transfers) (disaggregated by age, gender and pregnancy status)

Definition: This indicator is a sum of the two previous indicators (new and transferred), which are automatically summed in the spreadsheet. Sum 'number new on ART during the quarter' and 'number on ART who transferred in during the quarter' to capture all those started on ART during the quarter at USG

funded facilities. This data should be disaggregated by age (0-5 years, 0-14 years and 15 and over), gender (male and female) and pregnancy status (at the time of enrolment). Disaggregation of pregnant women by age is not required. The number of pregnant women is to be shown as a subset of all women started on ART.

Rationale/What it measures: This indicator provides an overall measure of the caseload of patients on ART during the quarter.

Inclusions/Exclusions: Include all new and transferred patients during the quarter. This indicator is auto summed in the Data Warehouse.

Strengths/Weaknesses: This is purely an output measure. It aims to capture all new patients starting ART during the specified time period.

8.15 Cumulative number started on ART by the end of the quarter (disaggregated by age, gender and pregnancy status)

Definition: Sum of the 'cumulative number started on ART by the beginning of the quarter' with 'number started on ART programme during the quarter (includes new and transfers)'. This data should be disaggregated by age (0-5 years, 0-14 years and 15 and over), gender and pregnancy status (at the time of enrolment). Disaggregation of pregnant women by age is not required. The number of pregnant women is to be shown as a subset of all women on ART.

"Cumulative" refers to the total number of individuals who were ever on ART since the start of PEPFAR support to the service outlet.

Rationale/What it measures: This indicator captures the cumulative number ever started on ART by the end of the quarter, not adjusting for loss to follow-up or death.

There are three programme indicators to count individuals receiving antiretroviral therapy at a service outlet directly supported by PEPFAR funds: new, cumulative, and current. Collectively, these three programme indicators, when combined with the required outcome indicator: care & treatment (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a programme in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.

Inclusions/Exclusions: The cumulative indicator is comprised of the new clients plus those clients who transfer with records into a programme directly supported by PEPFAR funds. The cumulative number of clients by the end of any reporting period is the sum of the cumulative number of clients at the end of the previous reporting period plus the clients who newly initiate and transfer into the programme during the reporting period.

The cumulative count never declines over time, as it represents the total number of individuals who were ever on ART, regardless of whether they died or otherwise left the programme. The same individual should never be counted more than once for the cumulative indicator. Thus if an individual previously on ART in the programme restarts ART after an interruption in therapy, this person should not be counted again in the cumulative count as s/he has already been counted. For the cumulative indicator, age represents an individual's age at initiation of therapy or when s/he transfers into the programme.

Disaggregation of pregnant women by age is not required. The number of pregnant women is to be shown as a subset of all women on ART.

Strengths/Weaknesses: As the health of ART clients improves and ART services become available at more locations, transferring patients may account for an increasing proportion of ART client load in the health care system and at any given facility. If treatment is not adequately documented or records are not transferred with a client, clients may be newly initiated at more than one programme/facility over time. At the country level, these clients will be double counted in the new and cumulative client indicators. Double counting of individuals within a programme area is to be avoided to the extent possible.

Since age and pregnancy status change over time, the comparison of new, cumulative, and current clients by age and pregnancy status is challenging. Because new and cumulative are states defined by beginning in a programme, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a programme. On the contrary, current is a state defined by vital/treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a programme.

8.16 Number on ART at the end of the quarter (CURRENT) (disaggregated by age, gender and pregnancy status)

Definition: The number of HIV-infected individuals who were still on ART on the last day of the quarter. This number is adjusted for the loss to follow-up, deaths, and those who stopped ART or transferred out. This data should be disaggregated by age (0-4 years, 0-14 years and 15 and over), gender (male and female) and pregnancy status (at the time of enrolment). Disaggregation of pregnant women by age is not required. The number of pregnant women is to be shown as a subset of all women on currently on ART.

Rationale/What it measures: There are three programme indicators that count individuals receiving antiretroviral therapy at a service outlet directly supported by PEPFAR funds: new, cumulative, and current. Collectively, these three programme indicators, when combined with the required outcome indicator: care & treatment (percentage of people still alive and on therapy at 6, 12, and 24 months after initiation of treatment) give an overview of the progress of a programme in achieving targets to begin and maintain individuals on long-term, antiretroviral therapy.

Inclusions/Exclusions: Patients who transfer in, transfer out, or who restart after interruption of therapy will be counted in the CURRENT client load, as long as they are on ART at the end of a reporting period.

A person on ART who initiated ART or transferred in during the reporting period can be counted as a current client if s/he is on treatment at the end of the reporting period. Individuals who died, stopped treatment, transferred out, or were otherwise lost to follow-up during the reporting period are **not** on ART at the end of the reporting period, and thus, are not counted as a current client. Note that the difference between the "cumulative number ever on treatment by the end of the reporting period" and the "current number on treatment at the end of the reporting period" should be approximately the number of individuals who died, who permanently stopped treatment or transferred out, or who were otherwise lost to follow-up by the end of the reporting period. In order to measure survival on ART and the number of current clients, all programmes should collect information on the number of individuals who are no longer on treatment at the end of a reporting period and the reason including death, stop treatment, transfer out, or loss to follow-up.

Patients pick up ARV drugs on variable schedules, and monitoring systems are not always adequate to flag and follow up each person who misses an appointment. Thus it may not be possible to get an exact count of current clients on the last day of the reporting period. The recommended method for calculating this indicator is to count the number of individuals who were seen for ARV therapy during the last three months of the reporting period (i.e., the last quarter) and to subtract those who were known to have died, stopped treatment, transferred out, or otherwise been lost to follow-up since the last time they were seen for a treatment appointment. Those not seen during the last three months are presumed lost to follow-up. For the

current indicator, age represents an individual's age at the end of the reporting period, or when last seen during the reporting period for an ART appointment. Disaggregation of pregnant women by age is not required. The number of pregnant women is to be shown as a subset of all women.

Strengths/Weaknesses: Monitoring systems are variable in their ability to measure exactly the client load at the end of the reporting period, thus the reported results may include some people who have recently died, dropped out, transferred out, or been lost to follow-up as well as overestimate the true number of clients at the end of the reporting period. Since age and pregnancy status change over time, the comparison of new, cumulative, and current clients by age and pregnancy status is challenging. Because new and cumulative are states defined by beginning in a programme, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a programme. On the contrary, current is a state defined by vital/treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a programme.

8.18 Number of health workers trained to deliver ART services

Definition: The number of health workers trained in the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection. Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies.

Health workers: this includes health workers that have been sufficiently trained to take up a direct function in support of scaling up clinical or community-based ART services. There are a variety of health workers including:

- Physicians and health workers with physician skills, such as medical officers.
- Nurses and other health workers with nursing skills, including midwives and clinical officers.
- Other health care workers and lay staff in clinical setting.
- Laboratory technicians and staff.
- Pharmacy/dispensing staff.
- Community treatment supporters including peer educators, outreach workers, volunteers, informal caregivers.

Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when these exist. The training must follow a curriculum that indicates the objectives and/or expected competencies. Training may be knowledge and/or skills and/or competency-based.

Rationale/What it measures: Building human capacity in health care delivery systems is of the utmost importance for the delivery of quality ART services. This indicator measures efforts to train a workforce to achieve targets in ART service delivery. Included are both certified clinical and lay health workers who contribute to the development and implementation of ART services.

Inclusions/Exclusions: An individual should only be counted once they have completed the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals should only be counted once during a reporting period even if s/he may have attended several training courses within the same period. If a training course covers more than one ART topic, individuals should only be counted once for that training course. If a training course is conducted in more than one session/training event, only individuals who complete the full course should be counted. Do not sum the participants for each training session.

Strengths/Weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures the number of staff trained in ART services as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.

This indicator is most useful in the initial phases of a response to HIV/AIDS, when the cumulative number of trained health professionals is expected to continuously increase until it reaches a critical mass or desired ceiling. This indicator does not measure the distribution of health workers trained to provide ART care services. This indicator does not disaggregate by the type of health worker trained to provide ART care services. This indicator does not measure the type, content or duration of training being counted, or whether the health workers counted as trained have been counted as trained in a previous period. Given the importance of human capacity to provide paediatric AIDS services, countries and/or programmes may wish to collect additional information on the number of health workers trained to provide paediatric ART services.

8.19 Number of health workers trained to deliver HIV palliative care (non-ART)

Definition: The number of individuals trained in palliative care services including symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management (and/or referral) of opportunistic infections including TB/HIV, malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; and social and material support, such as nutrition support, legal aid, and housing.

Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies.

Rationale/What it measures: The intent of the indicator is to measure progress toward a cadre of professionals trained in palliative (non-ART) care according to South African or international standards.

Inclusions/Exclusions: An individual should only be counted once they have completed the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals should only be counted once during a reporting period even if s/he may have attended several training courses within the same period. If individuals were trained in both ART care and non-ART palliative care, they can be included in this indicator and in the above indicator.

Strengths/Weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

8.19.A Number of individuals trained to provide TB treatment (subset of 8.19)

Definition: The number of individuals trained in providing TB services for HIV-infected individuals (diagnosed or presumed).

Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies.

Rationale/What it measures: The intent of the indicator is to measure progress toward a cadre of professionals trained to provide TB treatment.

Inclusions/Exclusions: An individual should only be counted once they have completed the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals should only be counted once during a reporting period even if s/he may have attended several training courses within the same period. Note: this is a subset of the 'number trained in (non-ART) HIV palliative care'.

Strengths/Weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance.

Cohort table for indicators 8.20-8.23

Note that this is not an indicator but is part of a table that provides information for indicators 8.22-8.25.

Definition: There should be one cohort for the reporting period. Therefore if they initiated ART in February, March or April, they would be counted in the September report.

Inclusions/exclusions: Include the months when the cohort started on ART using the following table:

Reporting period Patients being reported during the time quarter:	**6-month cohorts** Patients who started on ART in the preceding months of:	**12-month cohorts** Patients who started on ART in the previous year, during the months of:
October 1 - December 31	Feb, March, April	Aug, September, October
January 1 - March 31	May, June, July	November, December, January
April 1 - June 30	Aug, September, October	Feb, March, April
July 1 - September 30	November, December, January	May, June, July

8.20 Number of individuals in cohort (6 and 12 month cohorts)

Definition: The number of persons who have been on ART for 6 and 12 months.

Rationale/what it measures: This indicator provides a measure of the number of patients who adhere to ART at 6 and 12 months.

Inclusions/exclusions: If a person was transferred into the PEPFAR programme and has records of previous treatment records, including CD4 counts, they can be included in this indicator.
Do not include children under six for this indicator since the measurement of CD4 counts is different than adult measurement.

Strengths and weaknesses: Many patients will have incomplete records and thus this indicator will only include a select group of clients.

8.21 Number in cohort who have CD4+ counts (6 and 12 months cohorts)

Definition: The number of individuals in the cohort who have CD4+ counts. Baseline CD4 counts should be captured any time during the three-month period prior to starting ART or within two weeks of starting ART. The six-month CD4 count should be obtained between 4-7 months after initiating ART; the 12-month CD4 count should be obtained between 10-13 months after initiating ART.

Rationale/what it measures: The intent of the indicator is to measure the number of individuals on ART who are monitored with CD4+ counts. CD4+ counts are very important to monitor the clinical progress of individuals on ART and thus provide an indication of the quality of services provided.

Inclusions/exclusions: Only include those patients on ART who are part of the cohort.

Strengths and weaknesses: Regular monitoring of CD4+ counts for patients on ART is a key component of an ART programme. This indicator is an output indicator that indicates the number of patients who have received CD4+ tests.

8.22 Number in cohort who received ARVs for entire time period (6 and 12 month cohorts)

Definition: The number of persons in the six-month cohort who have received ART every month for the entire six-month period.

Rationale/what it measures: This indicator measures of the level of adherence to ART in the cohort.

Inclusions/exclusions: Only include those patients on ART who are part of the cohort and who have received ARVs for the entire 6 month or 12 month period.

Strengths and weaknesses: This indicator intends to measure treatment adherence. It does not, however, monitor the patient health outcomes (e.g. increase in CD4+, reduction of viral load).

8.23 Median CD4+ count for cohort (6 and 12 month cohorts)

Definition: The median CD4+ count for 6 and 12 month cohorts at baseline and at 6 or 12 month for the respective cohort.

Rationale/what it measures: This indicator measures the mean CD4+ count which indicates positive or negative health outcomes for persons on ART. Over time, CD4+ counts for persons on ART should increase over time.

Inclusions/exclusions: Only include those patients on ART who are part of the cohort who have CD4+ counts.

Strengths and weaknesses: This indicator aims to show strengths or weaknesses of an ART programme and is an outcome measure for people on treatment. However, many facilities that do not have advanced electronic patient tracking systems may have a difficult time obtaining such data for a cohort.

8.24 Number of patients on each regimen at the end of the quarter (by age)

Definition: For all current patients on ART, indicate the number of persons on each regimen. If a person changes regimens during the quarter, include only the current regimen. A patient should be recorded in this table, no matter the source of funding for ARV drugs.

Rationale/what it measures: Clinical management of HIV disease requires the monitoring of drug regimens. This indicator measures the number of patients on each regimen.

Inclusions/exclusions: Only include current patients on ART.

Strengths and weaknesses: This indicator attempts to identify the regimen distribution among adults and children and changes over time.

8.25 Number of persons who started on ART at the facility in the PEPFAR programme who were not on ART at the end of the quarter

Definition: Number of persons who started on ART at the facility in the PEPFAR programme who were not on ART at the end of the quarter and are thus lost to follow-up.

A person is considered lost to follow-up (LTF) if s/he has not been to clinic or picked up drugs for at least 3 months. Each category should be mutually exclusive. Since the reasons listed are not necessarily mutually exclusive, use this guidance for how to classify persons who experience multiple events:

- If patient transferred out, then was lost, count as transferred out.
- If patient transferred out, then died, count as transferred out.
- If patient transferred out, then stopped, count as transferred out.
- If patient stopped ARVs, then died, count as stopped.
- If patient stopped ARVs, then transferred out, count as stopped.
- If patient stopped ARVs, then was lost, count as stopped.

As much as possible, over time, a programme should try to re-classify the persons lost to follow-up as more information becomes available:

- If patient is lost, then transfers out, count as transferred out.
- If patient is lost, then dies, count as died.
- If patient is lost, then stops ARVs, count as stopped.

Rationale/what it measures: This intends to get a quarterly update on the status of all persons on who were started on treatment since the grantee began support to the extent possible.

The most recent status of persons who started on ART at the facility at any point since the beginning of the programme is tracked on a table that indicates the number of people who were on ART at any point since the launch of PEPFAR support, but who are not on ART at the end of the quarter. The total should equal the difference between the cumulative number started on ART and the total number on ART at the end of the quarter. These numbers are expected to change from one quarter to another as information is gathered and status can be updated. These numbers can go down as well as up. Death is a final state, but people can restart ART after stopping, can transfer back in after having transferred out, and can return to the programme after being lost to follow-up.

Inclusions/exclusions: Only include those patients no longer on ART.

Strengths and weaknesses: This indicator attempts to track health outcomes of treatment programmes. Tracking deaths, loss to follow-up, people who are transferred out, and those who stop treatment allows programme managers to identify strengths and weaknesses in ART services.

Indicators: Activities in Support of ART Services

8.26 Number of HIV-infected individuals provided with ARV treatment at the end of the reporting period (indirect)

Definition: The estimated number of HIV-infected individuals indirectly supported by USG that receive ART.

Indirect support includes any of the following: national, provincial, or district level policy development; institutional capacity building; logistics; protocol or guideline development; advocacy; national, provincial, district level training; and national, provincial, or district level management information systems.

Rationale/what it measures: There are a number of support functions that are essential for the provision of quality treatment services. This indicator measures the number of individuals who received treatment services and benefited from indirect support.

Inclusions/exclusions: Count only services that received indirect support. Those services that received direct support should be counted in indicators 8.1 to 8.25

Strengths and weaknesses: This indicator intends to measure support for ART services not at the facility level, but on a broader scale. It is difficult to measure the link between this type of support and attribution at the facility level.

8.27 Number of health workers trained to deliver ART services

Note: This indicator is the same as indicator 8.18, but it is intended to capture training activities for partners who do not support direct treatment programmes.

Definition: The number of health workers trained in the provision of antiretroviral drugs and clinical monitoring for antiretroviral therapy among those with HIV infection. Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies.

This includes health workers who have been sufficiently trained to take up a direct function in support of scaling up clinical or community-based ART services. Type of health workers include:

- Physicians and health workers with physician skills, such as medical officers.
- Nurses and other health workers with nursing skills, including midwives and clinical officers.
- Other health care workers and lay staff in clinical setting.
- Laboratory technicians and staff.
- Pharmacy/dispensing staff.
- Community treatment supporters including peer educators, outreach workers, volunteers, informal caregivers.

Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when these exist. The training must follow a curriculum that indicates the objectives and/or expected competencies. Training may be knowledge and/or skills and/or competency-based.

Rationale/what it measures: Building human capacity in health care delivery systems is of the utmost importance for the delivery of quality ART services. This indicator measures efforts to train a workforce to achieve targets in ART service delivery. Included are both certified clinical and lay health workers who contribute to the development and implementation of ART services.

Inclusions/exclusions: An individual should only be counted once they have completed the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Strengths and weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures the number of health workers trained in ART services as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.

This indicator is most useful in the initial phases of a response to HIV/AIDS, when the cumulative number of trained health professionals is expected to continuously increase until it reaches a critical mass or desired ceiling. This indicator does not measure the distribution of health workers trained to provide ART care services. This indicator does not disaggregate by the type of health worker trained to provide ART care services. This indicator does not measure the type, content or duration of training being counted or whether the health workers counted as trained have been counted as trained in a previous period. Given the importance of human capacity in providing pediatric AIDS services, countries and/or programmes may wish to collect additional information on the number of health workers trained to provide pediatric ART services.

8.28 Number of hours technical assistance provided for ART services

Definition: The number of person hours of technical assistance provided by the PEPFAR partner to local NGOs, national or provincial Departments of Health, or other institutions for building capacity to provide ART services. Technical assistance is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of programmes in the specified area.

TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Rationale/what it measures: This indicator measures the amount of technical assistance provided by USG technical experts in the area of treatment to governmental and non-governmental partners. It reflects capacity building efforts to improve programmes and develop policies in this area.

Inclusions/exclusions: Include person hours of technical assistance provided specifically for strengthening ART programmes and/or policies.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator attempts to capture an input into a process, but does not indicate the quality of the technical assistance provided or if the intended output was achieved.

Laboratory Infrastructure

Programme Overview

Development and strengthening of laboratory facilities to support HIV/AIDS-related activities, including the purchase of equipment and/or commodities, the provision of quality assurance, staff training, and other technical assistance.

Indicators

9.1 Number of laboratories with capacity to perform: 1) HIV tests and 2) CD4 tests and/or lymphocyte tests

Definition: This indicator measures the number of laboratories with the capacity to perform HIV tests and CD4 tests and/or lymphocyte tests. Laboratory capacity is defined as the ability to perform (1) HIV tests and (2) CD4 tests or lymphocyte tests. This refers to both the equipment and personnel necessary to carry out testing.

Rationale/what it measures: This indicator reflects USG efforts to strengthen capacities of laboratories to perform HIV/AIDS related tests, diagnostics and monitoring tasks.

Inclusions/exclusions: Only include those laboratories that receive direct USG support.

Strengths and weaknesses: This indicator does not measure whether the sites are actually performing the specified tests. This indicator does not consider the quality of service provision, which would require more in-depth evaluation efforts like facility surveys. This is not a complete measure of coverage, as there is no denominator of total facilities.

9.2 Number of tests performed at USG supported laboratories: 1) HIV testing; 2) TB diagnosis; 3) syphilis testing; and 4) HIV disease monitoring

Definition: The number of tests performed at USG supported laboratories during the reporting period (6 months/ 12 months). Tests include:

- HIV testing: Examples include ELISA and simple rapid tests for serology and polymerase chain reaction (PCR) for infant diagnostics.
- TB diagnostics: Acid fast (Ziehl-Neelsen) staining of sputum.
- Syphilis testing: Rapid Plasma Reagent (RPR), simple syphilis, Treponema pallidum hemagglutination assay (TPHA).
- Sreening and confirmation, and HIV disease monitoring: CD4, viral load, Alanin transaminase (ALT), and Creatinine.

Rationale/what it measures: This indicator measures the extent to which USG supported laboratories are expanding laboratory services to support HIV/AIDS care and treatment services.

This measure should reflect the number of tests performed, not the number of kits or reagents purchased. Measurement of this indicator is undertaken by systematically reviewing laboratory records maintained at each site, as well as USG project records and documents, to count the number of USG supported

laboratories performing tests within each of the categories listed above. The number of tests should be added within each category. For example, the number of HIV tests should reflect the sum of ELISAs, rapid tests, and PCRs.

Inclusions/exclusions: Only include tests for laboratories that receive direct USG support.

Strengths and weaknesses: This indicator is an output indicator of direct support provided to strengthen laboratories in a given country and for PEPFAR as a whole. Different sub-categories of HIV monitoring provide an overall picture of USG support. For management purposes, laboratories may want more detailed information about the tests performed.

When interpreting this indicator, consideration must be given to factors within and beyond USG manageable interests. For example, reagent stock outages and logistical problems greatly reduce the number of tests performed in labs. Often procurement and logistics are managed independently.

The ability of laboratory staff to report this information may lag behind their capacity to perform these tests. As a result, counts may underestimate laboratory performance. As record-keeping and reporting capacity of laboratories improve, so will the quality and accuracy of the indicator estimate.

9.3 Number of individuals trained in the provision of laboratory related activities

Definition: This indicator measures the number of individuals trained in the provision of laboratory related activities. Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when these exist. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

Rationale/what it measures: The indicator measures progress toward developing and/or maintaining the skills of a cadre of professionals such that they are able to provide laboratory services according to South African or international standards.

Inclusions/exclusions: Include only those individuals who received laboratory related training as operationally defined by the organization.

Strengths and weaknesses: This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in laboratory-related activities as opposed to the percent of health facilities with trained staff, which may be measured through health facility surveys.

Policy Analysis and System Strengthening

Programme Overview

Other HIV/AIDS-related activities including strengthening policies and systems to address stigma and discrimination, and to support national prevention, care, and treatment efforts; other activities to strengthen systems or build capacity to combat HIV/AIDS, include activities to support the implementation of national and/or multilateral programmes. Activities could also include the provision of technical assistance through small grants or assistance with proposal development, organizational management, network or coalition building, advocacy, and/or public/private partnership building.

Indicators

10.1 Number of local organizations provided with technical assistance for HIV-related policy development

Definition: The number of local organizations provided with technical assistance related to policy development.

Technical assistance is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of policy development activities. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Policy activities aim to:

- Broaden and strengthen political and popular support for HIV/AIDS policies and programmes;
- Improve the operational environment for these programmes, including better planning and financing;
- Ensure that accurate, up-to-date information informs policy decisions; and
- Build in-country and regional capacity to participate in policy development.

Rationale/what it measures: This indicator measures the number of local organizations reached by USG technical experts in the area of policy development.

Inclusions/exclusions: Only include local organizations (not international organizations) specifically provided with technical assistance for HIV-related policy development.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator does not indicate the quality of the technical assistance provided. If the total number of local organizations is known, then it would be possible to calculate the percentage of organizations reached with Strategic Information (SI) technical assistance.

10.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building

Definition: The number of local organizations provided with technical assistance related to institutional capacity building.

TA is defined as the identification of need, and delivery of, practical programmatic support for design, implementation and evaluation of institutional capacity building activities. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Institutional capacity building activities may include:

- Strategic planning: organizations that have a board of directors, mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals;
- Registration: organizations that are officially registered as legal entities;
- Financial management: organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets;
- Human resource management: organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all levels of the organization;
- Networks development: local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results;
- Commodities, equipment and logistics management: organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV and AIDS prevention, care and treatment services; and
- Infrastructure development: laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.

Rationale/what it measures: This indicator measures the number of local organizations reached by USG technical experts in the area of institutional capacity building.

Inclusions/exclusions: Include only local organizations (not international organizations) that were provided with technical assistance specifically for the seven categories listed above.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator does not indicate the quality of the technical assistance provided. If the total number of local organizations is known, then it would be possible to calculate the percentage of organizations reached with SI technical assistance.

10.3 Number of individuals trained in HIV-related policy development

Definition: The number of individuals trained in implementing programmes related to policy development activities. Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies. An individual should only be counted once they have completed

the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Policy activities aim to:

- Broaden and strengthen political and popular support for HIV/AIDS policies and programmes;
- Improve the operational environment for these programmes, including better planning and financing;
- Ensure that accurate, up-to-date information informs policy decisions; and
- Build in-country and regional capacity to participate in policy development.

Rationale/what it measures: Supportive interventions strengthen HIV prevention, care and treatment programmes. This indicator measures the number of individuals trained in policy development activities. As more and more individuals are trained in the different policy development domains, more individuals can be reached with HIV/AIDS services. In conjunction with indicator 10.1, this gives a picture of the reach of policy development activities.

The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programmes in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: Only participants who complete the full training course should be counted. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Strengths and weaknesses: The indicator documents any increases in the capacity to deliver policy development activities. However, this indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in policy development activities as opposed to the percent of organizations with trained staff.

10.4 Number of individuals trained in HIV-related institutional capacity building

Definition: The number of individuals trained in implementing programmes related to institutional capacity building. Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies. An individual should only be counted once they have completed the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Institutional capacity building activities may include:

- Strategic planning: organizations that have a board of directors, mission statement, and strategies for the short and long-term (5 -10 years), including diversification of funding sources and ability to write their own grant proposals;
- Registration: organizations that are officially registered as legal entities;
- Financial management: organizations that have a practical accounting system in place and are able to account for all expenditures in accordance with USG and in-country audit requirements, analyze unit costs, make financial projections, and track expenditures against budgets;
- Human resource management: organizations with an established personnel system with checks and balances, for recruiting, paying, retaining, training, and supervising adequate numbers of staff at all

levels of the organization;
- Networks development: local networks established/strengthened that deliver prevention, care and treatment services, monitor implementation, and report results;
- Commodities, equipment and logistics management: organizations that have established a system to assess commodity needs, account for donated product, ensure adequate drug supply at all times, and eventually procure and purchase supplies, equipment, and drugs for HIV and AIDS prevention, care and treatment services; and
- Infrastructure development: laboratories, clinics, and classrooms improved or renovated to provide HIV/AIDS training or services.

Rationale/what it measures: Supportive interventions strengthen HIV prevention, care and treatment programmes. This indicator measures the number of individuals trained in institutional capacity building activities. As more and more individuals are trained in the different capacity building domains, more individuals can be reached with HIV/AIDS services. In conjunction with indicator 10.2, this gives a picture of the reach of capacity building programmes.

The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programmes in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: Only participants who complete the full training course should be counted. Individuals attending more than one training in a particular program area during the reporting period should only be counted once.

Strengths and weaknesses: The indicator documents any increases in the capacity to deliver institutional capacity building activities. However, this indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in institutional capacity building activities as opposed to the percent of organizations with trained staff.

10.5 Number of individuals trained in HIV-related stigma and discrimination reduction

Definition: The number of individuals trained in HIV-related stigma and discrimination reduction. Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when these exist.

Count all individuals trained, from local organizations or otherwise, during the reporting period. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

HIV/AIDS-related stigma can be described as a “process of devaluation” of people either living with or associated with HIV and AIDS. This stigma often stems from the underlying stigmatization of sex and intravenous drug use—two of the primary routes of HIV infection. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or being perceived to belong to a particular group.

Stigma and discrimination reduction activities may include:
- Enhancing practical knowledge to reduce fear of casual transmission;
- Providing a safe forum to discuss sensitive topics (sex, death, drug use, inequity);

- Finding a common language to talk about stigma;
- Strengthening the capacity of people living with HIV and AIDS to challenge stigma in their lives;
- Providing a process to determine appropriate and feasible individual and community responses to stigma;
- Providing comprehensive, flexible tools for organizations to strengthen staff skills and develop or strengthen interventions to reduce HIV-related stigma; and
- Developing a system to compile and address reported acts of discrimination.

Rationale/what it measures: Supportive interventions strengthen HIV prevention, care and treatment programmes. This indicator measures the number of individuals trained in HIV-related stigma and discrimination reduction.

The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programmes in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: Only participants who complete the full training course should be counted. Individuals should be counted only once during a reporting period even if s/he attended several training courses that would be categorized under this same indicator during the same period.

Strengths and weaknesses: The indicator documents any increases in the capacity to deliver stigma and discrimination reduction activities and services. However, this indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in stigma and discrimination reduction as opposed to the percent of organizations with trained staff.

10.6 Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment

Definition: the number of individuals trained in HIV-related community mobilization for the prevention, care and/or treatment. Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when these exist. Count all individuals trained, from local organizations or otherwise, during the reporting period. A training must have specific learning objectives, a course outline or curriculum, and expected knowledge, skills and/or competencies to be gained by participants.

Community mobilization activities include:

- Identifying social groups and mapping existing formal structures or networks to encourage or promote HIV prevention, care and/or treatment interventions and services, such as counseling and testing, PMTCT, HIV care and antiretroviral treatment;
- Building trust with the community by providing a forum to discuss their perceived needs for HIV prevention, care and/or treatment interventions and services;
- Developing communication around social networks to engage in dialogue with the community which encourages or promotes HIV prevention, care and/or treatment interventions and services; and
- Creating media and events that expose community members to new ideas, involving them in problem solving, and encouraging innovations that promote HIV prevention, care and/or treatment interventions and services.

Rationale/what it measures: Supportive interventions strengthen HIV prevention, care and treatment programmes. This indicator measures the number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment.

The training must equip trainees with a minimum set of competencies needed to take an active role in supporting HIV/AIDS programmes in line with national recommendations and/or guidelines. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: Only participants who complete the full training course should be counted. Individuals should be counted only once during a reporting period even if s/he attended several training courses that would be categorized under this same indicator during the same period.

Strengths and weaknesses: The indicator documents any increases in the capacity to deliver prevention, care and/or treatment services through community mobilization. However, this indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator simply measures number trained in community mobilization as opposed to the percent of organizations with trained staff.

Strategic Information

Programme Overview

Strategic information (SI) includes activities related to HIV/AIDS surveillance, health management information systems (HMIS) and monitoring and evaluation (M&E), including development of improved tools and models for collecting, analyzing, and disseminating HIV/AIDS behavioral and biological surveillance and monitoring information; facility surveys; other monitoring and health management information systems; assisting countries to establish and/or strengthen such systems; targeted programme evaluations (including operations research); developing and disseminating best practices to improve programme efficiency and effectiveness; planning/evaluating national prevention, care and treatment efforts; analysis and quality assurance or demographic and health data related to HIV/AIDS; and testing implementation models, for example to support the development or implementation of Global Fund proposals.

Indicators

11.1 Number of local organizations provided with technical assistance for strategic information

Definition: The number of local organizations provided with technical assistance for strategic information activities. Local organizations include national government entities, local or provincial government entities, or other NGOs.

Technical assistance (TA) is defined as the identification of need, and delivery of, practical support aimed at improving the collection, reporting and use of SI including development of M&E plans, indicator definitions and data collection forms. TA should include regular technical communications and information dissemination sustained over a period of time. TA can be provided through a combination of strategic approaches and dissemination strategies including individualized and on-site peer and expert consultation, site visits, ongoing consultative relationships, national and/or regional meetings, consultative meetings and conferences, conference calls and web-casts, development and implementation of training curricula.

Rationale/what it measures: This indicator measures the number of local organizations reached by USG technical experts in the area of strategic information, which is critical to improving the quality of programmes and measuring the progress of activities.

Inclusions/exclusions: Include organizations that were provided with technical assistance specifically for strengthening Strategic Information (M&E, HMIS, and surveillance) policies and/or programmes.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator does not indicate the quality of the technical assistance provided. If the total number of local organizations is known, then it would be possible to calculate the percentage of organizations reached with SI technical assistance.

11.2 Number of individuals trained in strategic information

Definition: The number of individuals trained in M&E, HMIS and/or surveillance. Topics may include: developing or improving M&E models, methods and tools for collecting, analyzing, and disseminating and using data; establishing or improving information systems; developing or improving programme monitoring, planning and/or conducting targeted evaluations including operations research; monitoring and

disseminating best practices to improve programme efficiency and effectiveness; and improving data quality.

Training refers to training or retraining of individuals and must follow a curriculum with stated objectives and/or expected competencies. An individual should only be counted once they have completed the training. Individuals that are mid-way through a training should be counted in the next reporting period. Individuals should only be counted once during a reporting period even if s/he may have attended several training courses within the same period.

Rationale/what it measures: This indicator is a measure of individuals who have been trained in strategic information. It measures the number of newly trained or retrained individuals who are able to perform SI functions.

The training must equip trainees with a minimum set of competencies needed to take an active role in conducting strategic information tasks. Usually the presence of such competencies is assessed based on successful completion of training and practical experience during the reporting period.

Inclusions/exclusions: Only participants who complete the full training in SI, as operationally defined by the organization, should be counted.

Strengths and weaknesses: This indicator is useful in that it tracks the number of individuals trained to conduct strategic information functions. The indicator attempts to document increasing capacity to perform SI functions, however, no conclusion should be drawn regarding the quality of training nor does it measure the outcomes of the training in terms of competencies of the individuals trained or their job performance.

11.3 Number of hours of technical assistance provided for strategic information

Definition: The number of hours of technical assistance provided by the PEPFAR-supported partner to improve the collection, reporting and use of SI by local organizations including national government entities, local or provincial government entities, or other NGOs. Technical assistance for SI is defined as assistance aimed at improving the collection, reporting and use of SI including development of M&E plans, indicator definitions and data collection forms.

Rationale/what it measures: This indicator measures the amount of technical assistance provided by USG technical experts to local organizations in the area of strategic information, which is critical to improving the quality of programmes and measuring the progress of activities.

Inclusions/exclusions: Include person hours of technical assistance provided specifically for strengthening SI in programmes and/or policies.

Strengths and weaknesses: Technical assistance can cover a wide variety of areas. This indicator attempts to capture an input into a process, but does not indicate the quality of the technical assistance provided or if the intended output was achieved.

Appendix A: Glossary of Key M&E Terms

Abstinence only: Activities or programmes that *only* promote the importance of abstinence in reducing the prevention of HIV transmission among unmarried individuals; Decision of unmarried individuals to delay sexual activity until marriage; Development of skills in unmarried individuals for practicing abstinence; and adoption of social and community norms that support delaying sex until marriage and that denounce forced sexual activity among unmarried individuals.

Abstinence and faithfulness: Activities or programmes that promote abstinence combined with the importance of faithfulness in reducing the transmission of HIV among individuals in long-term sexual partnerships; Elimination of casual sex and multiple sexual partnerships; Development of skills for sustaining marital fidelity; Adoption of social and community norms supportive of marital fidelity and partner reduction using strategies that respect and respond to local customs and norms; and adoption of social and community norms that denounce forced sexual activity in marriage or long-term partnerships.

Activity: Specific actions or events implemented with the intention of reaching a given audience. Activities are what the programme or project does for the purpose of achieving its objectives. A given activity—when frequently repeated—constitutes an intervention or strategy (e.g., mass media programming, in-school life skills education). [1]
Synonym: Intervention

Analysis: The process of systematically applying statistical techniques and/or logic to interpret, compare, categorize, and summarize data collected in order to draw conclusions.

Assessment and Planning: The collection of information and data needed to plan programmes and initiatives. These data may describe the needs of the population and the factors that put people at risk, as well as the context, programme response, and resources available (financial and human).
Also: Needs Assessment

Baseline: The status of services and outcome-related measures such as knowledge, attitudes, norms, behaviors, and/or condition prior to an intervention.

Baseline data: Data describing the situation prior to intervention of a programme or project that serve as the starting point for measuring or demonstrating changes in that situation and the performance of the programme or project.

Behavior Change: Community Outreach: Community outreach behavior change activities outside of mass media, medical transmission, and STI management, aimed at preventing HIV transmission. This could include community mobilization, peer education, classroom, small group and/or one-on-one information, education, and communication (IEC) and behavior change communication (BCC) messages/programmes to promote avoidance of or reduction of HIV risk behaviors, and the social marketing and/or promotion of condoms. This includes work with high risk group such as intravenous drug users (IDUs), men who have sex with men (MSM), commercial sex workers (CSWs), and PLWHA, as well as activities (including training) to promote abstinence until marriage, delay of first sex, faithfulness, partner-reduction, and related social and community norms.

Case Study: A detailed review of a unique or important programme that captures the background, process, outcomes, successes, failures and lessons learned. The case study may include either qualitative or

[1] Bertrand, Jane T., and Manuel Solis. Evaluating HIV/IADS Prevention Projects: A Manual For Nongovernmental Organizations. **MEASURE Evaluation Manual Series, No. 10.** Carolina Population Center, University Of North Carolina At Chapel Hiss. July 2000. (Translation To English 2004).

quantitative data or both. The case study provides an opportunity to explore a single programme in-depth, but places the onus on the investigator to provide clarity, organization and scholarship to the investigation.[2]

Clients served: Count of people receiving services, disaggregated by sex.

Conceptual Framework: A framework that links trends in HIV prevalence to broad social and economic determinants through a set of biological and behavioral factors having a direct effect on HIV transmission.3

Comprehensive M&E systems do all of these things, of course, but they are also able to:

- Conduct formative assessments and research to support the conceptualization and design of new HIV/AIDS interventions and programmes;
- Conduct cost analysis, cost-effectiveness analysis and sustainability analysis; and
- Generate and use more strategic information in order to answer targeted evaluation and monitoring questions by linking various data sets from surveillance, population surveys, the HMIS, facility surveys, operations research, targeted evaluations, and other special evaluation studies.

Cost-Effectiveness Analysis: Cost-effectiveness analysis is an estimate of inputs in monetary terms and outcomes in non-monetary quantitative terms (e.g., reduction in HIV prevalence). A cost-effectiveness analysis involves assessing the gains (effectiveness) and resource input requirements (costs) of alternative ways of achieving a specified objective. The results are usually expressed in terms of cost per unit of effectiveness for each alternative. The alternative with the lowest cost per unit of effectiveness is the most cost-effective and is generally preferred on grounds of economic efficiency.[4]

Cost-effectiveness analysis helps managers and planners make decisions about the use of their budgets and funding. With this information decision makers can make choices about how to allocate their funds and decide whether or not the funds are being spent appropriately and whether they should be re-allocated.

Country Operational Plan: State Department Global AIDS Coordinator's Office (OGAC) work plan for the President's Emergency Plan for AIDS Relief.

Coverage: The extent to which a programme reaches its intended target population, institution, or geographic area.

Data Collection and Analysis Plan: A plan for collecting and analyzing the relevant and needed data to report on programme indicators and to assess impact of the programme.

Data Sources: Documents, databases, organization or surveys that will provide raw information or final figures for programme indicators.

Disease Surveillance: The ongoing systematic collection, analysis, and interpretation of data to describe diseases and their transmission in populations. These data can contribute to predicting future trends and targeting needed prevention and treatment programmes.

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[2] Master Glossary, The Synergy Project APDIME Toolkit Retrieved On July 23 From: Http://Www.Synergyaids.Com/Apdime/Mod_1_Assess/Assess_Index.Htm

[3] Alan Johnston, Senior DDU Specialist MEASURE Evaluation Project. Poster At The International Aids Conference 2000 Durban, South Africa, Entitled: "Interpreting HIV Trends For Policymakers: Using An Intermediate Variables Framework As A Policy Advocacy Tool."

[4] Creese A, Parker D. Cost Analysis in Primary Health Care, A Training Manual For Program Managers. Who, Geneva, 1994.

Dissemination Plan: A document that entails identifying the audience to receive programme information; communication strategies and a time line.

Economic Evaluation: Economic evaluations use applied analytic techniques to identify, measure, value, and compare the costs and outcomes of alternative interventions.

Effectiveness: A measure of the extent to which a programme achieves its planned results (goals, purposes and outputs).

Efficiency: A measure of how economically or optimally inputs (financial, human, technical and material resources) are used to produce outputs.

Evaluability Assessment: An approach used to determine a programme's readiness to be monitored and/or evaluated.
Synonym: Evaluability.

Evaluable Questions: Monitoring and evaluation questions that are typically based on stated programme objectives. These questions will determine what M&E data will be needed, as well as necessary data collection methods.
Synonym: Evaluation questions

Evaluation: Evaluation is the use of social research methods to systematically investigate a programme's effectiveness. It involves developing study designs; it sometimes requires control or comparison groups; it involves measurements over time; and it can involve special studies. More precisely, evaluation is a rigorous, scientifically based collection of information about programme activities, characteristics, and outcomes that determine the merit or worth of a specific programme. Evaluation studies are used to improve programmes and inform decision about future resource allocations.

Facility-Based Management Information Systems (MIS): Data management systems that facilitate the assessment of service uptake and coverage for facility-based interventions.
Synonym: Health Information System (HIS); Health Management Information System (HMIS)

Facility Survey: A site inventory of all elements required to deliver services such as basic infrastructure, drugs, equipment, test-kits, registers, and staff trained in the delivery of the reference service. The units of observation are facilities of various types and levels in the health system and will normally include both public and private facilities in the sample frame of sites.
Also: Service Provision Assessment.
Synonym: Inventory

Feasibility: The coherence and quality of a programme strategy that makes successful implementation likely.

Fiscal Year: The USG fiscal year is defined as the period from October 1 – September 30.

Formative Evaluation: A type of process evaluation undertaken during programme implementation to furnish information that will guide programme or project improvement. A formative evaluation focuses on collecting data on programme or project operations so that needed changes or modification can be made to the programme or project in its early stages. Formative evaluations are used to provide feedback to programme managers and other personnel about the programme components that are working and those that need to be changed.

Formative Needs Assessment: Process conducted during the planning or re-planning stage of a programme in order to identify programme needs and resolve issues before a programme is widely implemented. During a formative needs assessment the following issues are explored:

- Identifying the need for interventions;
- Defining realistic goals and objectives for interventions;
- Identifying feasible programme strategies; and
- Setting programme targets.

Synonym: Needs Assessment

Goal: A broad statement of a desired, long-term outcome of a programme. Goals express general programme intentions and help guide a programme's development. Each goal has a set of related, more specific objectives that, if met, will collectively permit programme staff to reach the stated goal.
Also see: Objective
Synonym: Ai.

Impact Assessment: Is the measurement of the health, economic status and quality of life of the target population. Impact assessment focuses on population-based measures. Certain study designs—called experimental designs—allow us to evaluate cause-and-effect with relative precision. With this type of design, we are able to measure the amount of change attributable to the intervention, eliminating the possibility that confounding factors unrelated to the programme influenced the results obtained. We can answer the question, "What would have happened in the absence of our programme?"[5]

Impact Evaluation: Impact evaluations look at the rise and fall of disease incidence and prevalence as a function of HIV/AIDS programmes. Impact on entire populations seldom can be attributed to a single programme or even several programmes.

Impact Monitoring: In the field of public health, impact monitoring is usually referred to as "disease surveillance" and is concerned with the monitoring of disease prevalence or incidence. This type of monitoring collects data at the jurisdictional, regional, and national levels.

Indicators: A quantitative or qualitative measure of programme performance that is used to demonstrate change and which details the extent to which programme results are being or have been achieved. Indicators can be measured at each level: input, process, output, outcomes and impact.

Input/Output Monitoring: Input and output monitoring involve the basic tracking of information about programme inputs, or resources that go into a programme, and about outputs of the programme activities. Data sources for monitoring inputs and outputs usually exist naturally in programme documentation, such as activity reports and logs, and client records, which offer details about the time, place, and amount of services delivered, as well as, the types of clients receiving services.
Also: Process Monitoring.

Logic Model: A programme design, management, and evaluation tool that describes the main elements of a programme and how these elements work together to reach a particular goal, such as prevention of HIV in a specific population. The basic elements in describing the implementation of a programme and its effects are: inputs, activities, outputs, outcomes, and impacts. A logic model graphically presents the logical progression and relationship of these elements.

[5] Bertrand, Jane T., and Manuel Solis. Evaluating HIV/Aids Prevention Projects: A Manual for Nongovernmental Organizations.

Synonym: Logical Framework, Logframe Matrix, Roadmap, Theory of Action, Concept Map, Model of Change, Blueprint, Theoretic Underpinning, Rationale, Causal Chain, Programme Theory, Chain of Causation, Programme Hypothesis, M&E Pipeline.

Monitoring: Monitoring is fundamentally the routine process of data collection and measurement of progress toward programme objectives. It involves tracking what is being done and routinely looking at the types and levels of resources used, the activities conducted, the products and services generated by these activities, including the quality of services, and the outcomes of these services and products.

As elaborated by UNAIDS, monitoring is the routine tracking and reporting of priority information about a programme and its intended outputs and outcomes. This is likely to include monitoring of inputs and outputs through record-keeping and regular reporting systems as well as health facility observation and client surveys.

Monitoring within a comprehensive M&E/SI system can also include the tracking of short-term programme outcomes (immediate outcomes), as well as intermediate outcomes and long-term impact. Such data frequently come from surveillance systems that track disease occurrence (impact) and risk behaviors (intermediate outcomes) using the same data collection system over time; and is typically performed at both the district and the national levels.[6]

Monitoring and Evaluation (M&E) Work Plan: A comprehensive planning document for all monitoring and evaluation activities within a national, USG, UNAIDS or HIV/AIDS/Health/Nutrition/Population programmes. This plan documents the key M&E questions to be addressed, what indicators are collected, how, how often, from where and why they will be collected; baselines, targets and assumptions; how they are going to be analyzed/interpreted and how/how often reports will be developed and distributed on the evolution of these indicators.
Synonym: Performance Monitoring Plan.

Monitoring and Evaluation (M&E) System: Fundamentally, an M&E system is a data system that tracks what is being done and whether programmes are making a difference. It enables programme managers to calculate how to allocate resources in order to achieve the best overall result. A strong M&E system that includes or is linked to a surveillance system can effectively addresses three key strategic questions that would be answered by the surveillance system: 1) What is the trend in HIV prevalence, especially among young people or other vulnerable populations? 2) If HIV prevalence among vulnerable populations increases or decreases, can this be attributed to changes in sexual behavior or other main determinants? 3) If sexual behavior or other main determinants change, can this be attributed to interventions?[7]

Objective: A statement of desired, specific, realistic, and measurable programme results.
Also, see: Goal
Synonym: (Performance) Target.

Operations Research: Operations research or operations evaluation applies systematic research techniques to improve programme outputs and outcomes, such as service delivery, service quality, and coverage. This type of research and evaluation analyses only those factors that are under the control of programme managers, such as improving the quality of services, increasing training and supervision of staff, and adding new service components. Operations research can be designed to assess the accessibility, availability, and quality of services, and the cost-effectiveness and sustainability of programmes.
Synonym: Operations Evaluation

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[6] UNAIDS. NATIONAL AIDS PROGRAMS – A GUIDE TO MONITORING AND EVALUATION. GENEVA, 2000.
[7] UNAIDS/WHO WORKING GROUP ON GLOBAL HIV/AIDS/STI SURVEILLANCE. *INITIATING SECOND GENERATION HIV SURVEILLANCE SYSTEMS: PRACTICAL GUIDELINES.* UNAIDS/WHO, GENEVA, 2002.

Outcome Evaluation: This is a type of evaluation that is concerned with determining if, and by how much, programme activities or services achieved their intended outcomes. Whereas outcome monitoring is helpful and necessary in knowing whether or not outcomes were attained, outcome evaluation attempts to attribute observed change to the intervention tested; describe the extent or scope of programme outcomes; and indicate what might happen in the absence of the programme. Outcome evaluations are methodologically rigorous and require a comparative element in its design, such as a control or comparison group.

Outcome Monitoring: Outcome monitoring is the basic tracking of variable that have been adopted as measures or indicators of the desired programme outcomes. For national AIDS programme outcome monitoring is typically conducted through population-based surveys to track whether or not desired outcomes have been reached. Outcome monitoring may also track information directly related to programme clients, such as change in knowledge, attitudes, beliefs, skills, behaviors, access to services, policies, and environmental conditions.

Palliative Care (non-ART care) Services/Programmes: All clinic-based *and* home/community-based activities aimed at optimizing quality of life of HIV-infected (diagnosed or presumed) clients and their families throughout the continuum of illness by means of symptom diagnosis and relief; psychological and spiritual support; clinical monitoring and management of opportunistic infections including TB and malaria and other HIV/AIDS-related complications; culturally appropriate end-of-life care; social and material support, such as nutrition support, legal aid, and housing; and training and support for caregivers. Given the need to independently track TB prevention, care, and treatment in an HIV palliative care setting, totals for palliative care are made up of the two service categories below: Basic Health Care and Support, and TB/HIV.

Participatory Approach: A broad term for the involvement of primary and other stakeholders in an undertaking (e.g. programme planning, design, implementation, monitoring and evaluation).
Also: Participatory M&E Planning and Implementation.

Policy Analysis and System Strengthening (Capacity Building): Other HIV/AIDS-related activities including strengthening policies and systems to address stigma and discrimination, and to support national prevention, care, and treatment efforts; other activities to strengthen systems or build capacity to combat HIV/AIDS, including activities to support the implementation of national and/or multilateral programmes. Policy analysis could include the provision of technical assistance through small grants or assistance with proposal development, organizational management, network or coalition building, advocacy, and/or public/private partnership building.

Policy Evaluation: Assessments of application and effectiveness of national, sub-national, district or other policies.

Prevention of Mother-to-Child Transmission Services: Activities aimed at providing the minimum package of services for preventing mother-to-child transmission including:

- Counseling and testing for pregnant women.
- Providing ARV prophylaxis to prevent MTCT.
- Counseling and support for safe infant feeding practices.
- Providing family planning counseling or referral.

Problem Statement: A statement that describes the nature and extent of the problem to be addressed by an intervention, including factors that put a population at risk. These factors may be related to knowledge,

attitudes, beliefs, behaviors, skills, access to services and information, policies, and environmental conditions. The problem statement often results from assessment and planning activities.

Process Evaluation: A type of evaluation that focuses on programme implementation, adding a dimension to the information that was tracked in input/output monitoring. Process evaluations usually focus on a single programme and use largely qualitative methods to describe programme activities and perceptions especially during the developmental stages and early implementation of the programme. These assessments may also include some quantitative approaches, such as survey about client satisfaction and perceptions about needs and services. In addition, a process evaluation might provide understanding about a programme's cultural, socio-political, legal, and economic contexts that affect the programme.
Also: Formative Evaluation; Mid-term Evaluation

Programme: A combination of interventions or activities that an organization establishes as a fundamental part of its structure and mission. Programmes tend to focus on a specific area such as HIV/AIDS or reproductive health, and operate over the long-term. Organizations develop programmes consistent with their mission and policies.[8]

Project: A combination of interventions or activities that an organization establishes in response to specific circumstances or needs. Projects tend to have a defined duration (e.g., 3-5 years). If a project is of particular importance to an organization, it may evolve into a programme. [9]

Proxy Indicator: A proxy measure is an indirect measure to obtain data that is indicative of the desired result. For example, it is too difficult to obtain information on whether a condom is actually used, so the number of condoms distributed is used as a *proxy* measure. Or, a project could count the number of individuals post-test counseled, to be the number counseled and tested. Although the testing wasn't done on-site, if a patient is being post-counseled, it can be assumed the testing was done.

Qualitative Methods: Qualitative methods such as interviews, focus groups, direct observation, and abstraction of written documents (such as programme records) can provide an understanding about social situations and interaction, as well as people's values, perceptions, motivations, and reactions.
Also: Interviews; Focus Groups

Quantitative Methods: Surveys and questionnaires used to systematically collect information for a carefully selected sample of individuals and households; provides data for evaluating achievement of outcomes.

Response Assessment: Also called a response analysis, a response assessment looks at the responses specifically as they relate to the priority areas identified in the situational analysis and it includes a map of the ongoing (and past) activities that have addressed HIV/AID, a determination of what interventions are working, which ones are not, what needs improvement, and where gaps have appeared in the response to date; and an examination of the problems faced by people living with HIV/AIDS.[10]

Rapid Assessment Process (RAP): An approach used for understanding perceptions, beliefs, practices, and behaviors of groups of individuals to plan or correct prevention activities mid-course. A combination of qualitative methods may be used instead of, or supplementary to, quantitative survey methods.
Synonym: Rapid Assessment

[8] Bertrand, Jane T., And Manuel Solis. Evaluating HIV/Aids Prevention Projects: A Manual for Nongovernmental Organizations.
[9] Ibid
[10] The Synergy Project. HIV/AIDS Programming Toolkit, Version 1.0. Washington, Dc, 2000.

Results Framework: A framework that lays out and links programme strategic objectives to overall objectives which arrive at the goal of the programme; usually depicted with the main programme goal at the top of the page, each of the main objective in its own box under the goal and the results feeding into each other from the bottom (result 1) to the top.

Service outlets/programmes: USG supported (see below). A service outlet refers to *the lowest level of service*. For example, with regard to clinical activities, the lowest level for which data exists should be a service outlet such as a hospital, clinic, or mobile unit. For programmes such as prevention efforts implemented through mass media or community outreach, the level at which the programme is counted is the level at which funds are obligated. For example, a national mass media programme is counted only once. However, if the USG is independently funding mass media programmes at the provincial level, each province's programme should be counted. Both terms (service outlet/programmes) are used to account for the different formats through which activities are delivered, i.e., prevention programmes and health care service outlets.

Situational Assessment: A process that describes the magnitude and dynamics of the problem in terms of the people who are most vulnerable and why they are most vulnerable, the number of people at risk and how they interact in ways that increase their vulnerability to HIV infection; and the social, economic, political, cultural and legal issues associated with the epidemic.[11]
Synonyms: Situational Analysis; Needs Assessment

"SMART" approach to writing objectives: A tool to determine whether or not objectives will be measurable and useful to programme planning. ***S****pecific:* Identifies concrete events or actions that will take place. ***M****easurable:* Quantifies the amount of resources, activity, or change to be expended and achieved. ***A****ppropriate:* Relates to the overall problem statement and desired effects of the programme. ***R****ealistic:* Provides a realistic dimension that can be achieved with the available resources and plans for implementation. ***T****ime-based:* Specifies a time within which the objective will be achieved.

Stakeholder: Person, group, or entity that has a role and interest in the goals/objectives and implementation of a programme.

Surveillance:

Behavioral: Repeat cross-sectional surveys of behavior in a representative population.

Sero or Biological: system to track infection levels (i.e. HIV) in populations accessed through "watch post" institutions (i.e. ANC). These institutions are generally already drawing blood or performing other biological tests for another purpose. Where blood (or other biological specimen are taken) is taken for other purposes, leftover sera can be stripped of all identifying markers and tested for infections (i.e. HIV) without the consent of the individual concerned.

Second Generation Surveillance: Systems that monitor HIV/AIDS risk behaviors, using them to warn of or explain changes in levels of HIV infection. This type of surveillance uses data from behavioral surveillance to interpret data gathered from sero-surveillance efforts.

Sustainability (of a programme): Sufficient likelihood that political and financial support will exist to maintain the programme while the evaluation is being conducted.

Sustainability Analysis: Sustainability analysis is a method to find a strategy that will produce an acceptable level of services at a cost the programme can afford while minimizing the threats to sustainability, i.e., the threats to maintaining a programme at a specified level of service. Sustainability analysis involves a financial assessment and a strategic assessment.

[11] IBID.

The financial assessment assesses the effects of the factors on future revenues and expenses, and how to project revenues and expenses over a period of time. (In one sustainability analysis computer programme, a computerized "what if" analysis allows one to change one's assumptions or mix of services and immediately see the effects on projected revenues and expenditures.)

The strategic assessment assesses ten factors that have been shown to be the most frequent potential threats to sustainability - or opportunities to enhance sustainability. These ten factors include:

- Population size and composition.
- Target group knowledge, attitudes, behaviors, and practices.
- Service quality.
- Management support.
- Organizational capacity.
- Political commitment.
- Personnel resources.
- Revenues.
- Expenditures.
- Environmental factors.

Strategic Information: Activities related to HIV/AIDS surveillance, HMIS and M&E, including development of improved tools and models for collecting, analyzing, and disseminating HIV/AIDS behavioral and biological surveillance and monitoring information; facility surveys; other monitoring and health management information systems; assisting countries to establish and/or strengthen such systems; targeted programme evaluations (including operations research); developing and disseminating best practices to improve programme efficiency and effectiveness; planning/evaluating national prevention, care and treatment efforts; analysis and quality assurance or demographic and health data related to HIV/AIDS; and testing implementation models, such as those developed to support implementation of Global Fund proposals.

Strategic Planning: A process for making informed, evidence-based decisions about how most efficiently and effectively to achieve a measurable change toward a defined and specific goal. More specifically, it involves identifying clearly articulated goals, objectives, targets, and the strategies and broad-based activities that will be required to achieve them over time.

Targets: Time framed benchmarks to be met by the programme during and after implementation; measured by the indicators of the programme.

Trained: Count of persons trained in a particular programmatic area. Training refers to new training or retraining of individuals and assumes that training is conducted according to South African or international standards when these exist.

Treatment Services: Activities including the provision of antiretroviral drugs and clinical monitoring for ART among those with advanced HIV infection in either an ART setting.

USG Supported: Any HIV service outlet/programme that receives at least some of its funding or support from the USG. It is likely that country service outlets/programmes will be supported by a mixture of funds from varied sources, including the USG. Because we cannot separate USG clients from other clients in an USG funded service or programme, all clients of an USG supported service or programme should be counted toward USG prevention, care, and treatment goals. In multi-service/programme institutions, please count clients for the service or programme component that is being funded. For example, if the USG is

contributing funds to support a PMTCT clinic in a large hospital, all clients in that PMTCT clinic should be counted as USG clients, regardless of other funding received by the clinic. However, if the hospital is providing ARVs in another clinic that does not receive USG funds, clients in that clinic should *not* be counted as part of an USG supported programme. If, for example, a programme receives USG funding for PMTCT and Global Fund funding for Counseling and Testing, only the PMTCT clients will be reported and the service outlet is counted under PMTCT. However, if the programme receives both USG and Global Fund funding for PMTCT, it is acceptable to report all clients served in PMTCT, as it would be very difficult to divide the clients served in some way.

Validity: The extent to which a measurement or test accurately measures what is intended to be measured.

APPENDIX B: Illustrative Examples of HIV-Related Palliative Care Services for Adults and Children

CLINICAL/PHYSICAL CARE		
Entrance & Adherence to Antiretroviral Treatment	Nutrition	Skin Problems
Entrance to Antiretroviral Therapy (ART)	Routine nutritional assessment and monitoring	Provision of Gentian Violet/ointments/other treatments to reduce HIV-related skin diseases
ART placement	Provision of micronutrient supplementation according to WHO guidelines)	Provision of symptom management* related to skin diseases and/or swelling
Routine clinical monitoring (for those on ART)	Provision of targeted nutrition supplementation according to WHO criteria	Bowel/Bladder Care and Genital Problems
Routine clinical monitoring (for those in need but not yet on ART)	Provision of targeted therapeutic nutritional feeding (WHO criteria)	Referral and prevention of diarrheal disease, constipation or incontinence
Routine clinical monitoring (for those not yet in need of ART)	Promotion of exclusive breastfeeding until weaning	Provision of symptom management* related to diarrheal diseases, constipation or incontinence
Provision of Post Exposure Prophylaxis	Support for appropriate, safe complementary feeding practices	Provision of Oral Rehydration Salts and/or zinc for diarrheal disease
Provision of side effect management related ART medications	Support for formula feeding if AFASS criteria met	Referral and prevention of genital problems (e.g. general infection, STI management, etc.)
Provision of symptom management* related to ART	Support for early weaning if AFASS criteria met	Provision of symptom management* related to genital problems (including management of genital discharge)
Treatment and Prevention of Opportunistic Infections	Provision of side effect management related to nutrition	Respiratory Problems
Provision of cotrimoxazole prophylaxis	Provision of symptom management* related to nutrition (includes loss of appetite, control of nausea/vomiting)	Treatment of HIV-related respiratory illnesses
Provision of prophylaxis for candidiasis (e.g. Diflucan)	Physical Care	Provision of symptom management* related to cough, breathlessness or respiratory disease
Provision of Isoniazid (INH) prophylaxis for TB	Provision of symptom management* for physical problems	Other Clinical/Physical Care
Treatment of Opportunistic Infections including Sexually Transmitted Infections (STI) (excluding TB)	Provision of wound care (prevention and treatment)	Appropriate use of universal precautions to protect the client and caregiver from transmitting HIV disease
Support for TB treatment adherence	Provision of oral care (prevention and treatment)	Psychiatric assessment and psychiatric treatment of HIV-related mental disorders
Provision of side effect management related to Opportunistic Infections, STI and TB therapies	Correct positioning and prevention and treatment of contractures in muscles and joints	Treatment and prevention of HIV-related malignancies
Provision of symptom management* related to Opportunistic Infections	Routine monitoring of vital signs	Clinical treatment of other HIV-related diseases
Treatment and Prevention of Malaria	Pain Management	Additional Pediatric Considerations
Provision of insecticide-treated bed nets	Screening for pain	Referral for early infant diagnosis (DBS)
Provision of intermittent presumptive treatment	Assessment of pain	Appropriate child survival interventions within HIV services (e.g. immunizations)
Other interventions to prevent or treatment of malaria in HIV-infected individuals	Treatment Step 1 (WHO analgesic ladder)	Routine growth and development monitoring
Provision of symptom management* for malaria	Treatment Step 2 and 3 (WHO analgesic ladder)	Other routine pediatric HIV care interventions
Provision of side effect management related to malaria medications	Referral for pain management	
	Provision of side effect management of pain medications	

Notes: HIV-Related Palliative Care is grouped in 4 categories: Clinical/Physical Care, Spiritual Care, Psychological Care, and Social Care; HIV-Related Palliative Care services may be provided in facility and community and home based settings; Education and Counseling related to each of the above service delivery elements is an integral component of palliative care service delivery.
**Symptom management may include screening, assessment, care, and treatment with appropriate symptom relieving-medications or therapies.*

SPIRITUAL CARE	PSYCHOLOGICAL CARE	SOCIAL CARE
Spiritual Support	Emotional Support	Social Support
Screening of spiritual problems related to HIV disease	Screening of emotional problems related to HIV disease	Screening of social problems related to HIV disease
Assistance with spiritual assessment	Participation in HIV-related support groups	Linking to food security interventions, income generation activities, livelihood strengthening interventions, etc.
Visitation by spiritual mentors, pastors, healers, imams, priests, rabbis, etc	Basic assistance with HIV-related agitation, fears, loss, worries, sadness, stigma-related issues or difficulties with sleeping	Linking to education, safe water and sanitation systems and other wrap around programs
Participation in spiritual support groups	Future life planning	Development of People Living with HIV/AIDS (PLWHA) support groups or People Affected by AIDS (PABA) support groups
Participation in religious events/ceremonies	Mental Health Care (non-psychiatric care)	Inclusion of gender-specific care activities (e.g. male involvement, screening for violence, etc.)
Participation in traditional healers groups	Screening and assessment for psychological problems by a trained professional	Assistance in accessing legal services or child protection interventions
Provision of prayer or guided meditation	Provision of counseling and/or psychotherapy for psychological problems by a trained professional	Assistance in accessing government grants/social welfare support
Preparing for and coping with death and the dying process	Provision of medication(s) that address psychological problems	Community mobilization and promotion of awareness of HIV and AIDS prevention, counseling/testing, care or treatment services
Spiritual Counseling	Other Psychological Care	Household and Family Support
Provision of life review and assessment	Support for disclosure of HIV status	Assistance with house cleaning, maintaining a hygiene and safe home environment or household repairs
Counseling related to hopes, fears, meaning and purpose, guilt and forgiveness	Support for HIV risk reduction behavior	Assistance with meal preparation, proper food storage, cooking or feeding
Assistance with life completion tasks	Provision of adherence counseling for Anti-Retroviral Treatment and opportunistic infection medication	Assistance with miscellaneous errands for the client or family
Other spiritual-related counseling by trained spiritual counselors or healers	Assistance with social interaction or therapeutic play	Provision of comfort measures for the client or family (e.g. quality communication and culturally-appropriate therapeutic touch, empathy and affection)
	Assistance with bereavement assessment	Assistance with assessments on household and family support (including genogram development, economic planning, etc)
	Provision of bereavement counseling	Preparing for and coping with death and the dying process
	Assistance with succession planning	Efforts to reduce HIV-related stigma
	Preparing for and coping with death and the dying process	Provision of measures that facilitate self-care and care for caregivers both physically and emotionally
		Supervision, mentorship and financial/incentive support for caregivers
		Training on the use of Universal Precautions at the household level
		Assistance client hygiene, bathing, or changing of linens/clothes
		Referral or provision of family planning interventions
		Referral for testing and counseling - pre and post

Notes: HIV-Related Palliative Care is grouped in 4 categories: Clinical/Physical Care, Spiritual Care, Psychological Care, and Social Care; HIV-Related Palliative Care services may be provided in facility and community and home based settings; Education and Counseling related to each of the above service delivery elements is an integral component of palliative care service delivery.
**Symptom management may include screening, assessment, care, and treatment with appropriate symptom relieving-medications or therapies*

APPENDIX C: Sample M&E Frameworks

1. Results Framework – USG

ACTIVITY	IMPACT	INDICATORS
	• Mitigate the Impact of HIV/AIDS in South Africa	• Morbidity and Mortality Figures due to AIDS • Life expectancy

	OUTCOMES	INDICATORS
	• Achievement of 2-7-10 Goals for South Africa (Reaching 500,000 with treatment)	• % of goal reached (X number of individuals receiving treatment/ 500,000)

	OUTPUTS	INDICATORS
	• Expansion of Treatment Service Delivery in South Africa	• Number of Individuals Receiving ARVs (Directly and Indirectly with USG support) • Number of Individuals on ARVs for a 12 month continuous period

	INPUT	INDICATORS
	• Trained Staff	• Number of Individuals Trained to Administer Treatment (or in any other specific area)

Note: Because of the large scope of the USG/SA programme, we can use national level indicators to assess outcome and impact. Each partner should narrow the indicators to the province, district or sub-district in which you are working.

2. Results Framework – Training at Partner Level

ACTIVITY	IMPACT	INDICATORS
	• Improving quality of life for HIV+ individuals in South Africa	• % of HIV + individuals eligible for treatment in South Africa (or could go to a more specific geographical area that you are working in, i.e.: province), who are receiving treatment • Morbidity and mortality for the same geographic area.

	OUTCOMES	INDICATORS
	• Increased competency of staff to deliver treatment	• % of individuals trained who are applying their skills six months after the training (follow-up survey)
	• Expansion of service delivery in treatment	• % of facilities in a specified geographic area who have trained staff (you could use sub-district, district or province depending on reach of your training programme)
	• Better quality service delivery in treatment	• % of facilities that have increased quality of service (The SA treatment accreditation criteria could be used or criteria could be developed – this would require a baseline and endline, which may or may not be feasible)

	OUTPUTS	INDICATORS
	• Trained Staff	• Number of Individuals who completed training to provide treatment (or in any other specific area)

	INPUT	INDICATORS
	• Money	• US$/SA Rand Allocated to Training in FYXX
	• Human Resources	• Number of individuals who initiated or registered for training
	• Development of Training Materials	• Number of hours spent developing materials • US$/SA Rand spent specifically on material development

1. Results Framework – Treatment

ACTIVITY	IMPACT	INDICATORS
	• Improved quality of life for HIV+ individuals and their families in South Africa (or at the level at which you are working)	• % on treatment who have returned to work • life expectancy

	OUTCOMES	INDICATORS
	• Make treatment more readily available for HIV+ individuals in South Africa (or at the level at which you are working)	• % of those eligible for treatment who are receiving ARVs
	• Increased adherence to treatment	• Number of HIV+ individuals who have been on ARVs for a continuous 6 months • Number of HIV+ individuals who have been on ARVs for a continuous 12 months • % of total that initiated treatment who reached the 6 or 12 month mark
	• Improved health of HIV+ patients	• mean CD4 count for patients receiving ARVs

	OUTPUTS	INDICATORS
	• Initiation of Treatment Programmes	• Number of HIV+ individuals receiving ARVs • Number of facilities that your organization is supporting a treatment programme
	• Ensuring that HIV+ Individuals are receiving a comprehensive package of services	• Number of HIV+ individuals (not on ARVs) who are receiving palliative care • Number of HIV+ individuals (on ARVs) who are receiving palliative care

	INPUT	INDICATORS
	• Human Resources	• Number of individuals who completed training in treatment service delivery
	• Money	• US$ or SA Rand Allocated to Treatment Programmes in FYXX
	• Procurement of Necessary Supplies	• % of funding spent on ARV drugs • %of funding spent on Salaries for nurses, doctors

Note: Depending on the focus of your programme, quality of service indicators could be added at the outcome level.

Appendix D: Indicator Protocol Reference Sheet

Template Sheet

Indicator Protocol Reference Sheet			
Name of Indicator:			
Result to Which Indicator Responds:			
Level of Indicator: Input Output Outcome Impact			
Is this a PEPFAR Core Indicator:			
Description			
Definition:			
Unit of Measure:			
Disaggregated by:			
Justification and Management Utility:			
Plan for Data Acquisition			
Data Collection Method:			
Data Source:			
Frequency and Timing of Data Acquisition:			
Estimated Cost of Data Acquisition:			
Individual Responsible:			
Location of Data Storage:			
Data Quality Issues			
Known Data Limitations and Significance:			
Actions Taken or Planned to Address this Limitation:			
Date of Initial Internal and External Data Quality Assessments:			
Date of Future Data Quality Assessments:			
Plan for Data Analysis, Review & Reporting			
Data Analysis:			
Presentation of Data:			
Review of Data:			
Reporting of Data:			
Other Notes			
Baselines:			
Targets:			
Other:			
Performance Indicator Values			
Year	**Target**	**Actual**	**Notes**
This Sheet Last Updated On:			

Appendix E: Data Quality Tools

Compiling the Data Quality Plan

1. Why do I need a Data Quality Plan?
It is essential that any data that is being collected and reported be of the best possible quality. This because decisions, related to the effectiveness and efficiency of any project, are based on the data collected during monitoring and evaluation. In order to ensure data quality and to avoid unnecessary and costly data repairs, a Data Quality Plan (DQP) is constructed in support of the Monitoring and Evaluation Plan (MEP) and in line with the Indicator Information Sheets (IIS). The DQP forms the basis for ensuring that the five critical elements of data quality, namely: validity, reliability, timeliness, precision and integrity, are given due regard during the planning for monitoring and evaluation and activity rollout. The DQP is an essential record of how the project managed its data quality issues and as such is an excellent source of information for the Auditor during a Data Quality Audit (DQA).

2. What is the significance of the 'Items' in column A?
The items listed in column A are broadly related to the Indictor Information Sheets but contextualized to address specific data quality issues that must be considered at operational level when planning the monitoring and evaluation activities.

3. What 'Explanations' are required in column B?
This is where the implementing partner explains how the requirements for data quality are realized operationally. For example: data quality, in terms of validity, is always dependent on the partner having a specific definition for the indicator they are reporting on. Although the indicator is defined in the IIS, it is important for the partner to explain the definition in terms of their programme, and to indicate what data is included or excluded during data collection in order for them to prove validity.

4. What is meant by 'Source / Records' in column C?
All implementing partners must be able to prove, during a DQA, that they have a data quality management system, which enables them to report data that is accurate, valid and reliable. In order to save the implementing partner and the auditor time it is always a good idea to list the ready sources of evidence / records which would demonstrate the information given in the DQP. This could be a list of document types, or record numbers, or references to academic works, or even a reference to a filing location.

5. How and why should I do a 'Risk Type' analysis as required in column D?

All data has an associated quality risk and sometimes the cost of managing the risk outweighs the additional benefit to be gained from improving the data quality. The use of a risk matrix enables the implementing partner to establish those elements within the data management system, which pose the greatest data quality risk so that the appropriate controls can be put in place to minimize the impact of a risk being realized in practice. Use the matrix given below to establish the data risk. Identify the probable frequency with which an error in the data could arise and assign the appropriate value. Identify how serious the error would be in terms of the overall effect on the quality of the data and assign an appropriate value. Multiply the two values together to get the risk score. Review the score against the risk analysis table below and take the appropriate actions.

Risk Matrix

Overall Effect on Data Quality	Probability of Error Occurring			
	(4) - Constantly	*(3) - Frequently*	*(2) - Occasionally*	*(1) - Unlikely*
(4) - Catastrophic	**16**	**12**	**8**	**4**
(3) – Critical	**12**	**9**	**6**	**3**
(2) - Marginal	**8**	***6***	**4**	**2**
(1) - Negligible	**4**	**3**	**2**	**1**

Risk Analysis Table

Risk Score	Risk Type	Remedial Action
9 - 16	**High Risk**	Establish contingency plan to reduce risk, verify and validate *prior to each reporting episode*, maintain strict audit trail.
4 - 8	**Medium Risk**	Establish contingency plan to reduce risk, verify and validate *prior to annual return*, maintain strict audit trail.
1 - 3	**Low Risk**	No immediate action required; risk could be managed through normal internal audit processes.

6. Where can I get more information to help me understand Data Quality?

ADS Chapter 203 – Assessing and Learning [http://www.usaid.gov/pubs/ads/200/]
TIPS 12: Guidelines for Indicator and Data Quality [http://www.dec.org/usaid eval/#004]

Data Quality Plan Table XX of XX

A. ITEM	B. EXPLANATION	C. SOURCE / RECORDS	D. RISK TYPE
1. Desired Outcome			
Indicator:			
2. Measure of Validity			
Unit of measure:			
Operational definition:			
Definitional inclusions:			
Definitional exclusions:			
Definitional bias:			
Desegregations:			
Operational justification:			
Source of data:			
3. Measure of Reliability			
Collection methodology:			
Collection instrumentation:			
Sampling frameworks:			
Collection personnel:			
Collection bias:			
Analysis methodology:			
Arithmetic manipulations:			
4. Measure of Timeliness			
Frequency of collection:			
Reporting frequency:			
Collection: Collation: Reporting time lags:			
5. Measure of Precision			
Source error:			
Instrument error:			
Sampling error:			
Transcription errors:			
Manipulation errors:			
Total margin of error:			
6. Measure of Integrity			
Cost of collection:			
Source integrity:			
Collector integrity:			
Anti-tampering controls:			
Data cleaning:			
Hard copy storage:			
Electronic storage:			
Internal audit:			
External audit:			

Data Quality Audit
Self-Evaluation Tool

Contract No:	**Review No:** of
Auditor:	**Audit Date:**
Partner:	**Activity(ies):**
Representative:	**Indictor Sheet Ref:**

Table One: Previous Data Quality Audits

Criterion	Yes	No	Add any comments you feel are required
Have you been subject to a Data Quality Audit in the past?			
If applicable, were any significant areas of non-compliance raised during the audit that related specifically to data practices in your organization?			
If yes, what were they, and how have they been addressed?			

Table Two: Indictor Information Sheets

Criterion	Yes	No	Add any comments you feel are required
Indicator Information Sheets (IIS)			
Do you have a copy of the IIS?			
Have you **fully** implemented the IIS for the data collection for which you are responsible?			
If not, please state reason.			
Has your organization developed and implemented a Data Quality Plan that enables you to meet the requirements of the IISP?			
If yes, has this process been documented?			
If yes, has this process been subject to internal review?			
If yes, has this process been subject to external review?			

Table Three: Evaluation of implementation of the IIS and DQP

Criterion	Yes	No	Add any comments you feel are required
Definition			
Are the precise definitions as given in the IIS and DQP applied consistently in the data collection process?			
If not, please state reasons.			
Desegregation			
Is the source data desegregated according to the criteria given in the IIS and DQP?			
If not, please state reasons.			
Does data manipulation need to take place for desegregation for reporting purposes?			
If yes, please state how manipulation typically takes place.			
Data collection methodology			
Have specific procedures been developed for data collection as per the IIS and DQP?			
If not, please state reasons.			
Has source data been tested for validity?			
Has source data been tested for reliability?			
Has source data been tested for integrity?			
Have updated IIS been submitted to the reporting authority?			
If not, please state reasons.			
Has data been collected at the stated frequency?			
If not, please state reasons.			
Has cost of data collection been as per the estimated cost given in the IIS and DQP?			
If not, please state reasons.			
Has any analysis of the data been conducted by your organization?			

Criterion	Yes	No	Add any comments you feel are required
If yes, please state the typical type of analysis e.g. descriptive statistics, inferential statistics, etc.			
Data quality issues			
Have any issues arisen that make you think that there may be a problem with data quality?			
If yes, please state what you think the problem is, and whether the problem may be of a general nature, or of a specific nature.			
Have any of the data limitations that are mentioned in the IIS and DQP resulted in higher than expected margins of error?			
If yes, please state how this has been addressed and reported.			
Data storage			
Is source data / primary data still accessible for review?			
If not, please state where the source data can be accessed from and how quickly.			

Table Four: General data quality issues

Please raise any general data quality issues, positive or negative, that you think are relevant.

Appendix F: Results of FY 05 Data Quality Audit: Recommendations for Partners and USG

The South Africa USG HIV/AIDS task force commissioned a local contractor to conduct Data Quality Audits (DQA) for a sample of USG South Africa partners / grantees. Data Quality Audits are a vital component within any monitoring and evaluation program and are an ideal tool to establish and verify the quality of both the data management system (DMS) and the data itself. Maintaining a strong DMS ensures that the data that are being used for decision making are both valid and reliable. The primary objectives of the DQA initiative were to:

- Build Capacity. All the audits were not handled as 'cold-fact' audits but on a 'consultancy' type basis where guidance and capacity-building formed an important part of the audit, especially in the light of understanding how a DMS should function. As part of the DQA process, the integrity and quality of the partner/grantee Data Management System (DMS) was assessed. The auditor was able to establish and identify risks to data quality and provide recommendations to both partners/grantees and USG to reduce such risks.
- Verify Reported Data. The USG task force also wanted to ensure that the data that are reported to OGAC are both valid and reliable by establishing that indicator definitions are interpreted accurately and consistently across partners/grantees.

In FY05, 24 USG partners/grantees received a data quality audit. The reported data from the FY 05 semi-annual report was audited. This report summarizes the findings of the DQA activities.

Partner Recommendations

The measures given below are recommended to improve the systems in general for the partners / grantees of the USG. Partners / grantees should:

- Ensure that the correct number of adequately experienced data management personnel is employed.
- Operationally define all their reported indicators and ensure that these are integrated into the daily business of the organization and are well-known and understood by all data management personnel.
- Invest sufficient resources into M&E in the form of, for example, a dedicated M&E person.
- Ensure that their M&E system is sustainable and maintained through, for example, ensuring succession planning.
- Always utilize the automatic form generated by the DW for data capture.
- Ensure that all the reported indicators have documented definitions that have been operationalized according to the everyday operation of the organization. It should be ensured that all data management personnel are familiar with and understand these definitions.
- Ensure that wording used on all collection / collation / reporting tools are identical within each organization and that the wording is unambiguous.
- Use the same tools, if at all possible, throughout their DMS, preferably right from collection through to reporting. If this is not possible then partners / grantees should determine the inter-tool Reliability to ensure that the same data is reported from all sites.
- Design and document a MER Plan that includes:
    - Specific procedures for the methodology of the handling of all data including given timelines for data capture where appropriate.
    - The recording of the dates of all various stages within the DMS in order to be able to determine areas of possible time delays.
    - A fully completed IPRS for each contracted PEPFAR indicator.
    - Succession planning to ensure the sustainability of the DMS.
    - The creation of a verifiable audit trail of the entire DMS.
    - Version control of all written documents.
- Implement internal data quality control systems at all levels to minimize transcription, manipulation and other data errors.
- Utilize collation tools, in for example MS EXCEL, to ensure consistency and to provide a verifiable audit trail for collation processes.

- Provide the MER Plan and all data handling methodologies to all data collectors in perhaps the form of a training session so that they can understand the entire DMS better and thus produce improved quality data.
- Validate data to the primary data source on a regular basis – it would be acceptable to use a sampling technique. These regular validations could, in fact, form part of the MER Plan.
- Ensure that the reported data from the sites is all of the stated reporting period to avoid Timeliness as well as to a certain degree Validity and Reliability issues.
- Identify the strengths and vulnerabilities of their DMS through regular, formalized internal reviews of the DMS so that the DMS can be improved upon. All data quality issues should be reported to the USG.
- Ensure that there is more than one (1) final data handler and reporter to minimize the risks to Integrity, all partners / grantees should If this is not possible due to resources, then the final reporter should copy all data handlers when the final report is submitted to the USG.
- Keep data, especially primary data sources, secure to minimize risk to Integrity.
- Invest sufficient resources into M&E in the form of for example a dedicated M&E person.

USG Recommendations

- Develop the conventions / parameters for all the indicators, especially for the direct and indirect definitions, to ensure standardization across all partners / grantees. It may even be advisable to provide exemplars for all indicators to avoid any misunderstanding of the set conventions / parameters.
- Ensure that the definitions being used by their partners / grantees are suitably matched to these broader indicator 'umbrella' definitions so that the partners / grantees report data that is the 'intended measure'.
- Set margins of acceptable error for quantitative indicators and distribute these to the partners / grantees.
- Provide training to all partners / grantees on:
    - the basics of total quality management with a focus on DMS and DQS so that they can understand the importance of the five (5) data quality criteria.
    - on basic statistics and the use thereof in the methods and procedures in the analysis of data. There should be an emphasis on the use of the analysis of data for the monitoring, and thus improvement, of the program.
- Utilize the delivery of quality data and the security of the data, from the primary source to the reported data, as the essential criteria for the acceptance of partners / grantees to PEPFAR funding.
- Plan regular DQA of partners / grantees on a rotational basis so that all partners / grantees have the benefit of the capacity building component of the DQA.

Appendix G: Additional M&E Resources

General

http://www.bja.evaluationwebsite.org/html/useful_links/index.html#Evaluation Related

This site provides extensive links to evaluation-related government agencies, associations, listservs, non-profit organizations, foundations, research centres, journals and on-line publications, how-to documents, as well as standards, assessment, measurement, instruments, data and statistics.

http://www.gao.gov/special.pubs/erm.html

This site contains an extensive list of evaluation research and methodology publications.

http://www.cdc.gov/eval/resources.htm

This site offers links to many resources on evaluation.

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Developing a Logic Model

www.insites.org/documents/logmod.htm
Everything You Wanted to Know About Logic Models But Were Afraid to Ask.
Connie C. Schmitz, Professional Evaluation Services, Minneapolis, MN &Beverly A. Parsons, InSites, Boulder, CO

This article provides an easy-to-understand description of logic models. It explains why logic models are developed, who should be involved in development, what logic models are based upon, and other relevant topics.

www.uwex.edu/ces/pdande/Evaluation/logicmodels.htm
Logic Model, University of Wisconsin-Extension (UWEX)

This Website provides a brief historical account of the logic model usage. Also provided are PowerPoint presentations that illustrate essential components of logic models. A bibliography is included on this site.

www.bja.evaluationwebsite.org/html/documents/stop1-4.html#chap2
Evaluation Guidebook, Projects Funded by S.T.O.P. Formula Grants under the Violence Against Women Act. Martha R. Burt, Adele V. Harrell, Lisa C. Newmark, Laudan Y. Aron, Lisa K. Jacobs (December 1997)

Chapter two of this guidebook is dedicated to the development of logic models. Steps for goal setting and objectives are described, as well as, instructions for developing a diagram for specific factors.

www.bja.evaluationwebsite.org/html/documents/evaluation_strategies_p3_7.html
Developing a Logic Model. Harrel, A. (n.d.). *Evaluation Strategies for Human Services Programmes.* Washington DC: The Urban Institute

In this article key points for developing a logic model are discussed, and an example with a diagram is given.

www.national.unitedway.org/outcomes/cmtyout1.pdf
Achieving and Measuring Community Outcomes: Challenges, Issues, and Some Approaches. (April 1999)

This PDF formatted article, created by the United Way, describes how to develop logic models, strategies and challenges surrounding using logic models, indicators for success, and other pertinent information concerning logic models.

www.open.org/~westcapt/evaluate.htm
Building a Successful Prevention Programme Western Regional Centre for the Application of Prevention Technologies. Step 7: Evaluation

This Website provides a plethora of information on building, planning and using a logic model for evaluation. Links to several evaluation tools and measures, including worksheets, sample questionnaires, and case studies.

Creating a Budget for Evaluation

www.the-aps.org/education/promote/plnbudget.html
Promoting Effective Programme Evaluation Expert Advice: Evaluation Tips and Resources

The American Physiological Society posted suggestions, made during the May 1998 Evaluation Exploration Conference, for planning an evaluation budget. The plan shows examples of itemized evaluation activities and attached expenses. A budget worksheet is also included.

Evaluability Assessment

Stahler GJ and Tash WR. *Innovative Approaches to Mental Health Evaluation*. New York/London: Academic Press, Inc., 1982

The findings of three evaluability assessments are illustrated in Chapter 8 of this book. Conditions under which successful evaluability assessments are discussed.

Fisher RJ and Peters L. The role of evaluability assessment in mental health programme evaluation. *Canadian Journal of Community Mental Health*, 4(2): 25-34. Fall 1985

This article describes evaluability assessment as a methodology designed to increase the appropriateness and utilization of evaluation studies. Three case studies in different mental health settings (a day programme, a home care programme, and a counseling programme) are presented which illustrate the various implications and benefits of evaluability assessment and underscore the recommendation that programme evaluation should almost always begin with an evaluability assessment.

Leviton LC, Collins CB, Laird BL, and Kratt PP. Teaching evaluation using evaluability assessment. *Evaluation*, 4(4): 389-409. 1998

While this article is largely about how to introduce students to the field of evaluation by using the technique of evaluability assessment, it also includes relevant sections on understanding the logic of programme delivery and the development of a programme model. The authors argue that evaluators will practice more optimally useful evaluation if they are skilled in eliciting and describing programme logic.